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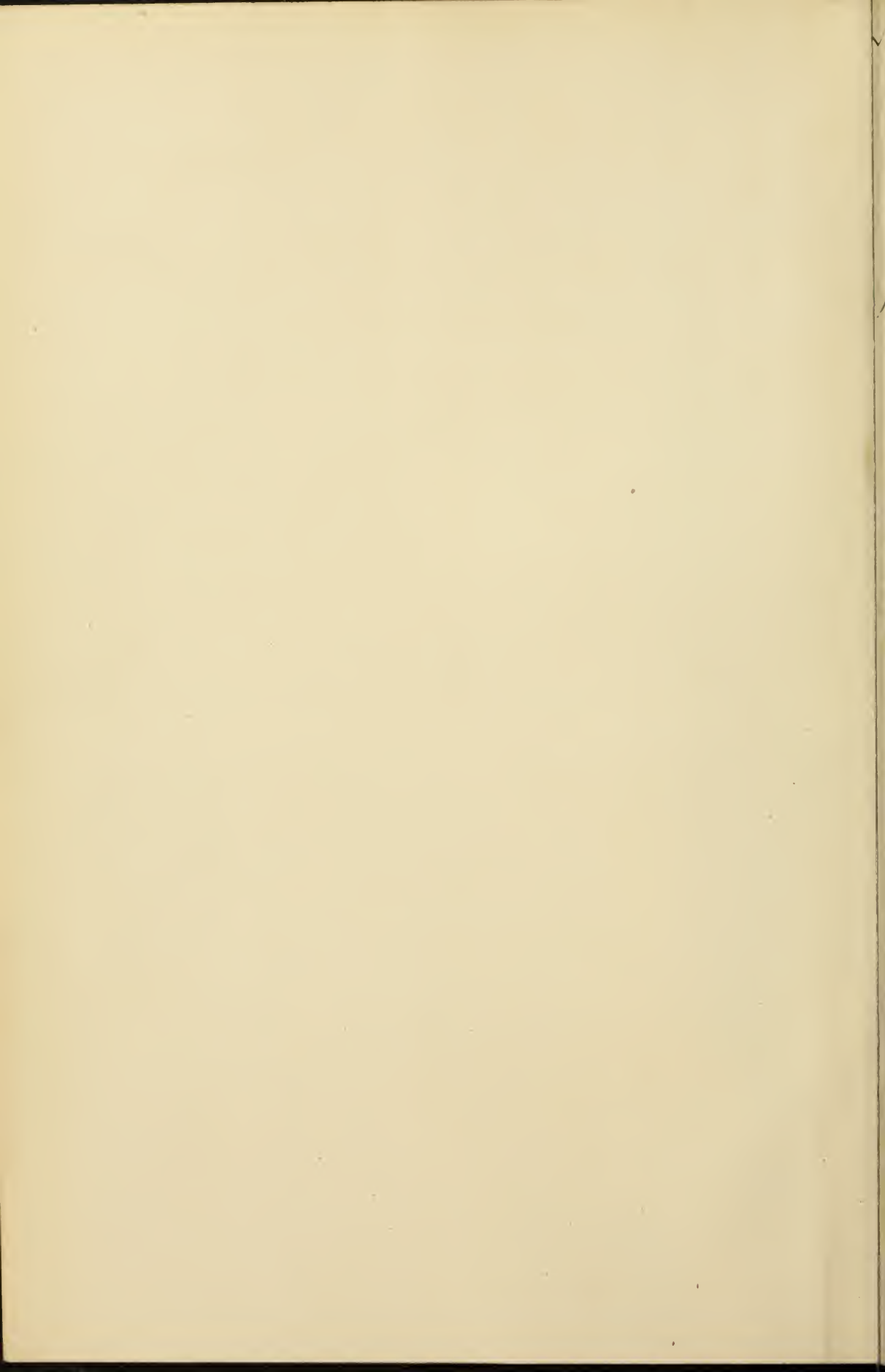






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# The Journal

OF THE



## South Carolina Medical Association

PUBLISHED EVERY MONTH UNDER THE DIRECTION OF THE  
COMMITTEE ON PUBLICATION.

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## South Carolina Medical Association

Next Annual Meeting at Columbia, S. C., April 20th, 1906.

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## 19454 THE JOURNAL

OF THE

SOUTH CAROLINA MEDICAL ASSOCIATION.

4 Vanderhorst Street, Charleston, S. C.

ROBERT WILSON, Jr.,  
Editor.T. P. WHALEY  
Associate Editor.

C. P. AIMAR, Managing Editor.

THE JOURNAL is published monthly under the auspices of the South Carolina Medical Association, to whose members it will be issued free. Secretaries of county societies are requested to send reports of the meetings, and items of news that may be of interest to the profession. Original articles are solicited. Illustrations sent with articles will be printed at the expense of the writer.

All matter must be in the hands of the editor by the 12th of each month.

## EDITORIAL COMMENT.

## THE JOURNAL OF THE SOUTH CAROLINA MEDICAL ASSOCIATION.

The publication of a medical journal in South Carolina is no longer a dream in the minds of a few—it has become a reality before the eyes of all. The need of a journal has long been felt, and five years ago Dr. W. P. Porcher, in his presidential address, suggested that we make an effort to this end. But it was not then considered practicable. Convinced that a journal would be of the greatest value in strengthening and maintaining our new organization, the House of Delegates, at the last meeting of the State Association, determined to venture upon such a publication, and entrusted its management to the present Board of Editors. *The Journal* is owned and published by the State Association, to whose members it will be issued free. Every member of the Association, therefore, has the interest of proprietorship and should regard it as a duty to work for its success. The co-operation of all is essential. The editors, a short time ago, sent a circular to the secretary of every county society, soliciting aid, and of the forty-one issued *only twelve responses were received*. Such lukewarmness will greatly increase the difficulties of the editors, whose earnest desire is to make *The*

*Journal* not only representative of what is best in medicine, but a means through which individuals and societies may keep in touch with each other and interchange ideas upon matters of general interest to the association and to the profession at large. We wish reports of the monthly meetings of the county societies and news items, such as deaths, marriages or removals, the progress of sanitary work, etc. Papers read before county societies are desired for publication. The State Board of Health and the Board of Medical Examiners are requested to publish reports of their proceedings. The editors fully realize the arduous nature of the undertaking, and urge upon every man the importance of contributing his share. For their part, they will welcome the frankest criticism, knowing that by such means alone will the best results be obtained.

## COMPULSORY VACCINATION.

The State Board of Health is to be congratulated upon the final success of their efforts to secure the enactment of a compulsory vaccination law. Year after year they have labored in vain for this end, contending with ignorance and its offspring, prejudice. But the persistence of the epidemic and the failure of all other means of suppression have at last convinced our wise men that the doctors knew what they were talking about when they said that vaccination alone would control the spread of smallpox. At a recent meeting, the State Board of Health adopted rules and regulations for putting into effective operation the compulsory vaccination act of the last General Assembly. These rules are published on another page and should be read carefully. It is the duty of every member of the medical profession to do all in his power to aid the Board in carrying out the provisions of the law.

## THE FIGHT AGAINST TUBERCULOSIS.

The first annual meeting of the National Association for the Study and Prevention of Tuberculosis was held at Washington, D. C., May 18-19. This

organization is composed of the most representative medical men in the United States, and was formed for the purpose of working systematically for the suppression of the Great White Plague. The necessity for spreading knowledge of tuberculosis among both laymen and physicians, tuberculosis from the layman's standpoint, the early diagnosis of tuberculosis, the channels of infection, the sanatorium treatment and other practical subjects relating to tuberculosis were discussed. At the last meeting of the State Association provision was made for the appointment of a committee on tuberculosis, to take up the work in South Carolina. This committee cannot begin too soon to formulate a plan of work. The need is great.

#### A GOOD EXAMPLE.

We wish to congratulate Chester upon the good example set by her medical men, as shown by the letter which appears in the correspondence column of this issue. Especially do we commend the movement to establish a medical library. To study books without clinical observation, says Osler, is like going to sea without a compass, but to study your cases without books is equivalent to not going to sea at all. Books are indispensable to the physician who aims to keep abreast of the progress of his profession, and to weave into his life those gracious influences which are suggested by the word culture. We believe that the only other medical library in South Carolina is the precious possession the Charleston County medical society, which also enjoys the distinction of being the third oldest in the United States, having its origin in a donation by Drs. Robert and Samuel Wilson in 1791. We trust that the medical society of Chester will meet with success in the high endeavor they are making for the advancement of knowledge and the promotion of peace and good-will.

#### PRESIDENT'S ADDRESS.

ROBERT WILSON, JR., M. D.

*Gentlemen of the S. C. Medical Association:*

In discharging the duty of delivering an Annual Address, which is required by our Constitution, permit me in the beginning to express my profound sense of appreciation for the distinction of having my name inscribed upon the honor-roll of your Presidents. It is no small thing, to receive from your hands the mantle of the illustrious men who in times past have occupied this chair, and out of a full heart I tell you that I have been deeply touched by this testimony of your esteem and confidence. The duties and the responsibilities of the high office, especially at this transition time, are such as would tax the power and try the merit of a stronger and a worthier man, and if I fail to measure up in full to the stature of my predecessors, I pray you be lenient and judge me in the end by Browning's standard,

"'Tis not what man does which exalts him,  
but what man would do."

With the adoption last year of our present Constitution, we have entered into league with our sister societies of other states, for the high purpose of elevating and purifying medical standards, and waging aggressive war against the forces of ignorance and fraud. This union of state societies, which has for its aim the consolidation of the entire medical profession in the United States into one compact organization, whose several component elements shall work together with singleness of purpose and in harmony of action for the attainment of lofty ideals, is a plan whose magnitude and grandeur may well inspire the imagination, and stimulate enthusiasm and fervent zeal. Such a union cannot fail to generate a moral motive power of tremendous force, which, if rightly utilized, will ensure the success of any righteous undertaking.



But, in order that this great scheme may reach perfection, and the medical body of the country become a power to be reckoned within the counsels of the nation, it is first essential that the profession in each state be thoroughly organized, and be made an active working unit. How we may accomplish this unification, and what work we have to do in South Carolina, shall be the subject of my address this morning.

In the newly adopted plan of reorganization, the county society is the unit and the State Association is simply a federation of county societies, so that membership in the latter, constitutes of itself membership in the former, and through no other channel is membership in the state association obtainable. Hereafter, no man who does not belong to a county society—no man who is unwilling to contribute his time and his labor to the up-building of his local profession—is eligible for membership in the State Association. The fundamental purpose of this union is, in the language of our constitution, to “extend medical knowledge, and advance medical science; to elevate the standard of medical education,” as well as to bestow the benefits which always spring abundantly from fellowship and mutual intercourse. But unless every individual realizes his personal responsibility to fulfill in himself the weighty obligations thus imposed, the obligations of self-culture and self-development, to extend his own medical knowledge and elevate his own standard of medical education, these purposes will surely fail. We must think more of our selves and less of others, more of our own shortcoming and requirements, and beyond all, more of our own personal and professional character and less of what other men are doing and how they are behaving; unless it be to emulate their virtues. We of the medical profession have a reputation for petty bickering, and I fear that there is a moiety of truth in the charge that we sometimes debase our noble and time-honored ethics by making it merely an excuse for striving over inconsequential

questions. But, as long as we allow individual differences to separate us, petty jealousies and selfish effort to waste our strength and absorb our life, the great aims to which we have consecrated ourselves can never be accomplished. The essentials to success are unity and harmony in action and earnestness in work. There is the keynote. The county society must be an active and potent factor in the life of the community, not a mere passive instrument for obtaining membership in the state association. It can be done. It is no Utopian dream. No magic spell is needed. The transforming force by which the latent powers may be awakened to active, moving energy, is work. That is all. Hard, sincere, self-sacrificing work. Work that is done thoroughly and earnestly, with no thought of self, but with a spirit “thirsting only for the truth.” The society whose members are animated by such a spirit will soon develop an educational influence of such potency that no man can afford to remain on the outside; and further, the influence of such a society will broaden out and make itself felt as a vital factor in the life in the whole community; directing its thought, correcting its errors, and solving many of its problems. The annual meetings of the state association will be infused with a new life. You will bring with you the results of your work and receive fresh stimulus for renewed activity. But, what can the county society do? How can it get to work? In the first place, the meetings must be frequent. A quarterly or semi-annual meeting is insufficient for the maintenance of an active interest; and if the organization is going to be a success, interest must be aroused and sustained. To this end, it is all important that the meetings be not only monthly or bi-monthly, but they must be attractive and profitable. They must be worth attending. Whatever else is done, a paper should be read at every meeting and free discussion encouraged. Every man should regard it as a moral obligation to contribute his share in turn. Let no one say he doesn’t know enough. Few know so little that they cannot teach

somebody something. And no man is so learned that he cannot learn something from another. Produce! Produce! If it be but the pitifulest infinitesimal fraction of a product, produce it in God's name! 'Tis the utmost thou hast in thee; out with it then." You will find that the preparation of papers based either upon your own individual work and thought, or upon the observations and experiments of others, and submitted to the criticism of your colleagues, will be an invaluable means of extending your own medical knowledge and of cultivating the indispensable habits of accuracy in thought and in reading, in observation and in expression. It may be instructive and stimulating to hear a well-written article, or to listen to a critical discussion, but it is vastly more beneficial to do the writing and the discussing yourself. Such work will also have the tendency to discover and develop individual predilections and so lead to the higher cultivation of natural aptitudes by limitation and concentration. Concentration is the secret of fruitful labor. Concentrate your energy upon a few things and bye and bye you will produce something. It is this necessity for limited application in order to bring forth the best results that has led to the development of specialism, that is such a marked feature of our age. The abundant harvest brought forth each year in every field is witness of its good results. Every day some new discovery is made and every year marks a substantial progress in some direction. To keep pace with this activity in all departments of our science is impossible for any single mind. The time has passed when one man can compass the entire field and master the whole of medicine and the whole of surgery, and to make the effort is to sacrifice efficiency in both. It would be a wise thing, and profitable to both the profession and the public in general, if in our larger centres of population an effort were made to accomplish the distinct separation of medicine and surgery. Under modern conditions it is not likely that medicine in South Carolina will attain its full development and occupy a po-

sition in the forefront, until we have a few men who restrict their activities and concentrate their energies, thinking more of the character of the work they do, than of the size of income they may earn.

I have said that the county society should exert an influence upon the community at large. One of the greatest obstacles against which we have to contend is the ignorance of the laity; and while we condemn this ignorance, and sometimes wonder at its magnitude, we forget that it is largely our own fault, for, who can overcome ignorance save those who possess knowledge? We are the proper teachers of the public. And one of the foremost duties of the county society, is by every means at its disposal, by public lectures, by newspaper articles and by individual effort, to create an enlightened public sentiment upon such vital matters as school hygiene, the pernicious effects of eye-strain, the spread of acute infectious diseases, the influence of vaccination, car sanitation, house ventilation, the prevention of tuberculosis, and a host of other subjects which spring to mind upon the mere suggestion. It is your duty, furthermore, to assert yourselves as advisors of the community in the sanitary construction of all public works. No school, or jail, or theatre should be erected without your judgment concerning its hygienic arrangements and surroundings, no system of drainage should be adopted or constructed without your approval. All that is necessary to secure your recognition as an authority in these matters, is that the Society work as a unit. In the City of Charleston, the Medical Society, under the masterly guidance of one of its members, by force of united action and earnest and dignified bearing, has succeeded, in the face of strong opposition, in winning from the City Council the entire management, business as well as professional, of the public medical service. And what has been done there can be done anywhere if the same course be pursued. It is an object lesson to all. It is by such a course of action as I have outlined for county societies, that the medical profession will be able to impress the public



mind with faith in its ability to guide them and to teach them. And we want most urgently an enlightened public if we are to overcome quackery and charlatry. Ignorance is the parent of credulity, and credulity fosters and nurtures quackery. It is useless, as we should know by recent experience, to seek the passage of laws forbidding quackery, as long as there is a credulous public. Our first duty is, manifestly, to teach the people what the profession of medicine is; what mighty works it has accomplished in the past; what it is now accomplishing; and what it aims to do. We must teach them the truth, if we would have them see error. And here I want to speak of a practice wherein we ourselves are sometimes guilty of questionable conduct, and ask you to consider by what means we may overcome it for we must free ourselves from error before we can teach others. I refer to the prescribing by physicians of patent and proprietary combinations. It would seem hardly necessary to speak in an assembly of physicians who are guided by our principles of ethics, of the impropriety of using or of recommending a patent preparation, but reliable druggists have informed me that such preparations are sometimes sold on physicians' prescriptions. But if we are not often guilty of the grave breach of using a compound that is technically a "patent medicine," the same cannot be said of the use of proprietary preparations with which the market is flooded, and of which many belong practically, if not technically, to the same obnoxious category. A preparation whose true composition is hidden behind a copyrighted name and kept in secret is surely no better than a "patent medicine;" and to use it is just as grave an offense. In using such compounds we are misrepresenting our knowledge and imposing upon our patients' confidence and trust, and are therefore guilty of immoral conduct. There are, it is true, many elegant preparations, which we can hardly afford to dispense with, and whose use is no violation of the strictest interpretation of our ethics, and perhaps it may be hard at times to exercise

a just discrimination. Personally I would prefer to sacrifice some of these rather than employ any of the other class, regarding it as a good working rule to use no preparation which has a trade name that is not descriptive of its composition.

You are probably aware that the Board of Trustees of the American Medical Association have created an Advisory Board, to be known as the Council on Pharmacy and Chemistry of the American Medical Association, whose duty is to attempt a solution of this difficult matter on a broad but ethical basis, trying to do full justice to the manufacturer, the physician and the public. It is their purpose, as set forth in the preliminary announcement, "to examine into the composition and the status of the various medical preparations, which are offered to physicians, and which are not included in the United States Pharmacopeia, or in other standard text books or formularies. The preparations will include the synthetic chemical compounds, as well as the so-called proprietaries and pharmaceutical specialties put out under trade marked names. Preparations which conform to the standard established by the ten rules governing the matter, will be incorporated in "New and Non-Official Remedies," a book to be published by the Journal of the American Medical Association." This is a great work and merits the hearty co-operation of the entire medical profession, which is invited. I would respectfully suggest that, for our own guidance, this matter be made the subject of inquiry, by a special Committee, who shall report at the next annual meeting.

To this Committee may also be referred an inquiry, concerning the practicability of suppressing improper advertising. Our daily papers are filled with advertisements which are shocking to every one who has a just appreciation of decency and honor, and of some of these it may be truthfully said that the false statements which they make are the least objectionable feature. In some instances false and misleading advertisements are published over the signatures of reputable druggists—men of unimpeachable per-



sonal character, but who adhere to the fallacious principle that business and private honor should be measured by different standards; a principle, which, in its application, simply means that a lie is harmless if it be profitable. But putting aside the moral phase of this question, there is another phase of it with which we physicians are even more concerned; for doubtless we can all recite from memory instances which have come to our knowledge of the evil wrought upon the innocent sick by this method of deception. But what can we do? I believe that if we take up this matter in the proper spirit, with the S. C. Pharmaceutical Association and with the S. C. Press Association, meeting them with frankness and candor, something may be done to lessen the evil. At any rate let us remove from our shoulders the heavy responsibility that is resting there, by making a sincere and earnest effort.

Here I may appropriately introduce the suggestion of an enterprise which will greatly assist us in carrying on this work, as well as all other in which we may engage. The publication of a monthly Journal, instead of a volume of annual Transactions. Indeed, the more I have considered this matter, the more convinced have I become that such a publication is now a necessary part of our working machinery. It is essential, if we propose to maintain the organization which we are endeavoring to perfect. Through its pages we shall be able to keep in touch with each other throughout the whole year, to exchange ideas and discuss matters of general interest. It would exert an incalculable influence in making us what we ought to be and what we aim to be—an effective, working unit. Not the least of its benefits would be the educational power it would wield, even beyond the exclusive ranks of the medical profession. Let us, therefore, no longer busy ourselves with the query: "Can we do it?" but, making up our minds that it shall be done, enquire only as to the best and most economical method of its accomplishment. Our annual Transactions cost us about four hundred dollars. A

Journal of twenty-five or thirty pages, would probably cost in the neighborhood of one thousand dollars. This at first glance appears a large sum and almost beyond our straightened means; but our income unquestionably will be in the future much larger than it has been in the past, and the burden consequently lighter. Another fact to be considered is the income to be derived from the advertising pages, which will probably go far toward paying the cost of publication. The House of Delegates should take up this matter at once and decide upon it at this meeting in order that no unnecessary delay be occasioned.

But let us turn again to the consideration of our field of work. In the past years we have made earnest and persistent efforts to secure the passage of just laws pertaining to medicine and sanitation, but year after year we have the same tale to tell of fruitless labor. There have been three causes of our repeated failures. First, the want of a General Assembly educated and enlightened upon these special matters; second, the want of unity and harmony among ourselves, without which earnestness and sincerity and unselfish action will bear no fruit; and third, a faulty method of presenting our desires to the General Assembly. The overcoming of the first of these difficulties is a heavy task, requiring an educational crusade, and the responsibility of carrying it on, rests on the shoulders of every man of us. In order that the work of the Legislative Committee may be effective, the individual influence of every member of the Association is essential; each man must do his share in moulding public sentiment. This is a hard thing to do, but patience and determination will bring victory in the end. The second cause of failure, the lack of sympathy and understanding between the Legislative Committee of the Association and the Executive Committee of the State Board of Health, which has so often been the occasion of the two bodies working at cross purposes, may be more easily removed. A systematic plan of procedure must be followed. These two bodies should con-

fer through the chairman of each and formulate a definite statement, setting forth our most urgent requirements. This statement should then be brought to the attention of every county society, either through the pages of the *Monthly Journal*, or by means of printed circulars addressed to the Secretary of each society to be read at one of the monthly meetings. In this easy and simple way every member of the Association would be made familiar with what we want from the Legislature, and could exert himself intelligently within his sphere of influence. The result would be that the members of the General Assembly would be prepared to listen to our suggestions with discrimination and to act upon them with judgment. But in the presentation of these suggestions we must not make the often repeated blunder, the third error, of invading the State House in force, which only has the effect of creating opposition at the very outset. One representative from each body, preferably the chairman, will be more effective than a larger number. Under the new constitution two members of the Committee on Legislation are likewise members of the House of Delegates, the President and the Secretary of the Association. Would it not be wise to amend the constitution, so that the Executive Committee of the State Board of Health be allowed a representative in the House of Delegates, bringing that body into closer touch with the business section of the Association? Likewise the Board of Medical Examiners should be represented in the House of Delegates, constituting as they do such an important part of our working machinery. These changes are commended to your thoughtful consideration.

I cannot mention the Board of Medical Examiners without dropping an expression of sincere appreciation in the name of the Association for their conscientious and earnest work, in endeavoring to maintain a high standard of requirement for medical practice. They have given freely of their time, often at personal sacrifice; and deserve our hearty thanks for what they have accomplished,

and our earnest co-operation in their struggle with existing problems.

In framing the present law, regulating the practice of medicine in South Carolina, it was intended that all, without discrimination, to whom may be committed the sacred charge of ministering to the sick and suffering, should prove their qualifications before a competent board of examiners. But, in its passage through the General Assembly, the bill was so modified as to exempt from such a test a class of practitioners who call themselves Osteopaths; and in its amended form it has become the Law. It is needless to comment upon the injustice and the wrong of such exemption. It is class legislation and therefore contrary to the genius of our law. To assert that Osteopaths do not practice medicine, because they do not administer drugs, is mere quibbling; for all who attempt to diagnose disease and to treat morbid processes, are practitioners of medicine; it matters not what school may claim their allegiance. But there is another and a graver fault. The amendment provides "that nothing in this Act shall in any way affect any person having a diploma from any legally chartered and regularly conducted school of Osteopathy. Provided further that nothing in this Act shall be so construed as to allow Osteopaths to prescribe medicine and practice surgery." By this Act these people are given full permission to treat disease; no limitation is placed upon their practice. Women in the perils of childbirth, young children and old persons suffering with all fleshly maladies may receive treatment at their hands. The law permits an Osteopath to treat the innocent victim of diphtheria, but forbids him to administer antitoxin. It allows him to treat one suffering with an inflammation of the vermiform appendix, but prohibits him from using the only means which, in many cases, will save the patient's life. Is not this most extraordinary? Here is a law which gives the freedom of practice to a class of people whose incompetence is recognized by the restriction that is immediately laid upon them. If they are competent to diagnose and treat dis-



ease, why should they not employ the life-saving measures of medicine and surgery, if they be so minded? That they are not so minded, does not affect the inconsistency of the law. It is singular, indeed, that intelligent people, such as our legislators are supposed to be, should fail to perceive the errors of a system, whose sole resource in overcoming the manifold pathological changes which occur in the human body, is a single mechanical procedure. All things are accomplished by manipulation. Hear the absurd claim of a professor in a well known College of Osteopathy: "There is, therefore, known to us a power which can originate actions and functions, a clear spring of volitional creativeness, and manipulation is the scientific means of its arousal, development and consummation." And yet, the supporters of this practice are not found only among the uneducated. It is evident that our professional duty requires us to do something to save the public from this delusion. But, what can we do? How can we reach the root of this evil? I regret to say that as things are now, I think it would be a mistake to return to the General Assembly and openly oppose the law. The underlying cause is a lack of information on the part of the people. We must, therefore, in the first place, make a general and sincere attempt to educate the public, teaching them the patent fallacies of the system. And I may say here that education of the public should begin in childhood. If the fundamental facts of anatomy, physiology and hygiene were taught in every school and college, a solid foundation would be laid on which we could more surely build. As I have said before, the only weapon with which we can hope to prevail against credulity is knowledge, and our main hope of overcoming the fallacy in question is an educational crusade. In the second place, we might interest ourselves actively in the election of legislators. This has been done, we are told, most successfully in other states, the physicians using their great personal influence in a quiet way to secure the election of proper candidates; and, what has been done elsewhere, can

also be done here. At any rate, it is worth the trial.

There is one more topic, which I wish to bring before you, and which before all others, merits your thoughtful and earnest attention—the tuberculosis problem. You are familiar with the facts, but let us look them in the face once more. Year after year this relentless minotaur claims his tribute of innocent victims. Year after year repeats the tale of desolated homes and empty lives, of vanished hopes and aching hearts. Year after year falls the withering blight, not upon the hoary-headed at whose feet the sickle is already laid, but upon men and women in the prime of productive life—Francois Xavier Bichat, Rene Théophile Laennec, Wm. Kingdon Clifford, Baruch Spinoza, John Keats, Henry Timrod, Sidney Lanier and Robert Louis Stevenson are only a few of the world's best, who, in the midst of fruitful lives, fell before the scourge.

In many places the active work that has been undertaken in the application of preventive measures has appreciably lowered the mortality, but in South Carolina the ratio of deaths from tuberculosis continues very high. Accurate statistics from the entire State are not available, but the carefully compiled figures, published by the Charleston Board of Health tell a truly melancholy tale. In 1903, 12.4% of the white deaths and 15.8% of the negro deaths were due to tuberculosis; 14.8% of all deaths, or 1 in 6.7; and these are average figures. Look at these facts in another light. There are now living in Charleston nearly 3,000 white people and 5,000 negroes who will surely die of consumption if these ratios be maintained. It is very probable that we can justly apply these proportions to the whole State, in which case approximately 190,000 of the present population will die of tuberculosis. Just think of it! And the majority of those who die are producers. Furthermore, the nature of the malady is such that not only are those afflicted withdrawn from the producing class of the population, but they are converted into consumers of a most expensive kind, for in addition to being

clothed and warmed and fed, they must be nursed and ministered unto at the expense of private purse or public treasury for a prolonged period. Again, remember that the stricken one is frequently the bread-winner of a family and the restriction of his bread-winning capacity, or the complete loss of it, must necessarily entail an appalling amount of suffering. And yet this disease is both preventable and curable. Surely we in South Carolina should no longer delay in joining the great struggle that is everywhere waging with increasing earnestness and effectiveness against the strongest and most unrelenting enemy of our race! We are just as capable as others of stemming the stream, if we would but bend ourselves to the effort, and not let private labors engross our whole time and thought. Perhaps it is the magnitude of the undertaking that has discouraged us, and made us feel the helplessness of fighting; but if so, we may gather courage and hope from what others have accomplished, and set ourselves bravely to the task.

If tuberculosis is preventable, why is it not prevented? Clear the answer comes: Simply because the mass of people are ignorant of the means of prevention. Here once more I have occasion to emphasize the teaching function of the physician. If we are to make any headway at all, we must see to it that systematic instruction be given to the laity concerning the modes of communication and the means of preventing the transmission of this disease. In every community the medical society should take up this matter and endeavor to arouse interest by means of public lectures to which the laity are to be invited. These lectures may be given by members of the local profession, or by leading men from the larger centres. The notification of tubercular cases should be required by the boards of health, not only on account of the valuable statistical information to be thereby gained and the assistance it would render in carrying out proper disinfection, but also because such notification would more strongly impress upon the minds of the people the dangerous infective charac-

ter of the disease, and thus be a useful educational measure. In order to unify and systematize this work, as well as to broaden its scope, I would suggest that a committee, consisting of one member from each county society be appointed, to be called the Committee for the Study and Prevention of Tuberculosis, which shall work under the auspices of the State Medical Association. This Committee may arrange lectures to be given in different sections of the state, disseminate literature if practicable, keep in touch with the work of the National Association for the Study and Prevention of Tuberculosis, and make an annual report to the State Medical Association. The second proposition which I have laid down concerns the curability of tuberculosis. The pioneer work of Brehmer and Irudeau has demonstrated beyond possibility of dispute that a very large percentage of cases of tuberculosis, if diagnosed in the early stages, may be cured. It has likewise been shown that cure is not necessarily dependent upon climate, thus opening the door of hope to the poor who cannot afford a prolonged residence at some costly resort. Realizing the economic value of human life, many States have erected sanatoria for the treatment of the consumptive poor; and South Carolina should follow their example. To be effective these institutions need not be expensive. Sanatoria built upon the plan suggested by Dr. Herbert Maxon King, of the Loomis Sanatorium, Liberty, N. Y., cost about one hundred dollars for each patient, and the running expenses in our climate would not be heavy. I would propose that this association make a strong effort to secure from the General Assembly an appropriation for this purpose. Already I hear some of you telling me how useless it will be to seek money from the General Assembly, for you have had experience with its members and are familiar with their ways. But my faith is great in the ultimate triumph of all good work prosecuted with sincerity, and with a spirit that refuses to be discouraged; and I believe that if we set in motion the educational methods suggested,



even though we fail this year and next year, by the third year we will have created a public sentiment so strong, that the General Assembly will not be able to refuse our request.

And now, my friends and fellow-workers, one word in conclusion. The burden of my message to-day has been that the justification of our new organization will be its usefulness—usefulness to ourselves and usefulness to others—that in order to make this aim a reality and not an empty dream, we must stand shoulder to shoulder and work. I have attempted to point out a few of the fields wherein our labors are most urgently needed, and to show how they may be made fruitful. If any of my suggestions should appear at first Utopian, consider well before you pass a final judgment, and you will later come to feel with me that if an end be just, it only needs for its attainment that we join ourselves together,

"Strong in will  
"To strive, to seek, to find and not to yield."

### FIBROMA OVARIUM, WITH TWISTED PEDICLE AND MARKED ASCITES.

BY LINDSAY PETERS, M. D., COLUMBIA, S. C.

The patient is a white woman 28 years old, a cotton-mill employee, referred to me by Dr. William Weston. She was admitted to Columbia Hospital on June 25, 1904. She gave no history of hereditary diseases in her family, except that her maternal grandfather and one maternal uncle had "consumption."

She has had two children. The first child was still-born at the 7th month of gestation eleven years ago, the second is living and 9 years of age. Both labors were normal and there were no unfavorable sequelae.

Menstruation began at 14 years of age. It has always been regular, every 4 weeks until last March. The periods have gen-

erally lasted 4 days and have never been attended with much pain.

She has had malarial fever from time to time since early childhood. Also had meningitis when a baby. Has never had typhoid fever, pneumonia, pleurisy nor rheumatism. Has always enjoyed good health until this Spring, her weight last winter having been 150 pounds.

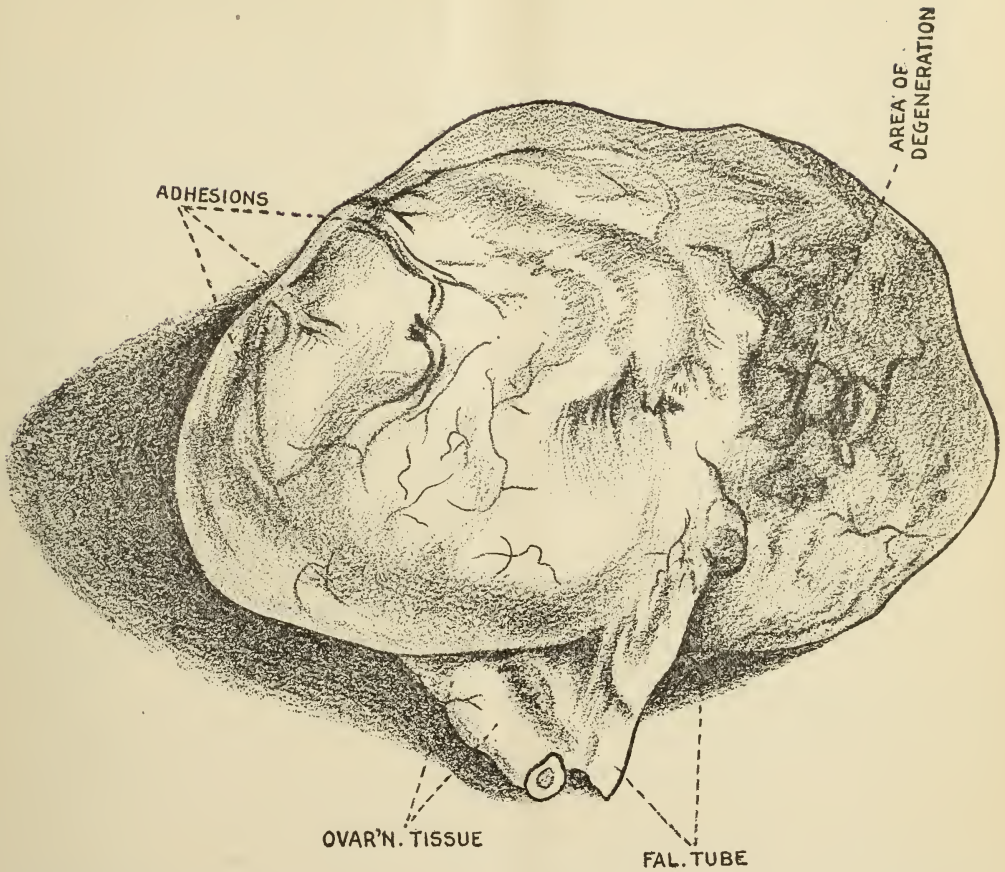
**PRESENT ILLNESS.**—After the birth of her 2nd child (9 years ago) the patient noticed a "swelling" in the lower part of the left side of the abdomen just above and in front of the anterior superior spinous process of the ilium. It was at that time not painful and gave no inconvenience, but has gradually increased in size until an attack of illness last March, which confined her to her bed four weeks, since which time the swelling has increased rapidly and now distends the abdomen. The illness just mentioned began with sudden, severe pain in the left side of the abdomen, extending down into the pelvis on the same side. This severe, paroxysmal pain lasted one day and was then followed by fever and soreness all over the abdomen. There was also diarrhoea and when she first began to sit up her feet were swollen.

The menses did not appear during March, but returned, with their usual characteristics, about April 1st. She has not menstruated since then. Since the illness just described there has been a rapid loss of flesh and also some dyspnoea on slight exertion. On the whole, however, she feels well and is not aware that she has any fever, although her chart since admission to the hospital shows an evening rise to 99°. She has slight, dry cough, no expectoration.

**EXAMINATION.**—The woman is of medium height, much emaciated and anaemic.

In the chest there are the physical signs of thickening of the left pleura.

The abdomen is greatly distended, with bulging of the flanks. The percussion note is flat all over the lower part of the abdomen and for about two inches above the level of the umbilicus. Above this the abdomen is tympanitic.



Fibroma ovarii, showing area of degeneration resulting from twist of pedicle. (Slightly reduced.)

On striking the abdomen on one side a percussion wave is transmitted across to the hand on the opposite side, thus demonstrating the presence of fluid.

On palpation an irregular, solid, nodular mass, estimated to be about the size of two fists, is felt. It occupies chiefly the middle of the lower part of the abdomen and its upper limit is about 2 inches below the level of the umbilicus. It has a wide lateral range of motility and exaggerated ballotment is produced by tossing the mass from side to side with the tips of the fingers. There is only slight tenderness.

The vaginal outlet is parous, not relaxed. The cervix is torn, firm and lies in the axis of the pelvis. By bimanual

touch motion of the abdominal mass is found to be imparted to the uterus.

The lateral structures are not distinguishable.

Urine . . . No albumen.

With the above data from the history and physical examination a provisional diagnosis of myoma uteri, with ascites and tuberculous (?) pleurisy was made, although tuberculosis of the internal genitalia and malignant pelvic tumor were also mentioned as possibilities.

For the purpose of reinforcing the patient's impaired vitality operation was deferred for a week, the patient being kept in bed and given tonics and a liberal diet. Her condition was noticeably improved



even in so short a time. The day before operation she weighed 113½ pounds.

OPERATION.—July 2, 1904. The abdomen was opened by a mid-line incision extending from the symphysis pubis upward for about 17 centimeters. On making a small opening in the peritoneum a jet of clear, straw-colored fluid, containing a few, small, fibrinous clots, escaped. This was allowed to flow out gradually, and 2½ liters were collected. About ½ liter was lost and about ½ liter was afterwards mopped out of the abdominal cavity. The tumor, of a purplish gray color, presented immediately beneath the incision. It was free from adhesions except on its anterior surface, where the omentum was rather firmly adherent. This was tied off and severed. On attempting to deliver the tumor through the incision by seizing it with tumor forceps, its superficial tissues were found to be softened by degeneration, so that the teeth of the forceps tore out. The tumor was then delivered by introducing the hand beneath it. Its origin from the left ovary was now for the first time discovered. Its pedicle, consisting of the left Fallopian tube and broad ligament, was twisted, a complete turn of the tumor being required to restore the normal relations. The pedicle was easily tied off with light silk, cut through and the tumor removed. After covering the stump with peritoneum by means of a continuous suture of fine catgut, the incision was closed in consecutive layers, catgut sutures being used for each.

In sponging out the abdominal cavity just before closing the incision a small purplish cyst was found free in Douglas' cul-de-sac.

PATHOLOGICAL EXAMINATION. — The specimens consist of (1), a tumor, a Fal-

lopian tube and a portion of an ovary and (2), a small cyst.

1. The tumor is ovoid in shape and measures 17x12x8 centimeters. It is throughout hard and dense except as mentioned below. It is for the most part smooth, but in places has a mammillated or nodular appearance. The surface of the tumor which faced anteriorly is darker in color than elsewhere, having a purplish, mottled appearance. The tissues in this area are somewhat softened, evidently beginning to undergo degenerative change. Here and there on the anterior surface a few tags of adhesions are seen.

The pedicle of the tumor is composed of the left Fallopian tube, left broad ligament and an elongated mass of ovarian (?) tissue. The tube is 6 centimeters long, .5 to 1 centimeter in diameter and entirely normal in appearance. It is attached to the tumor by its fimbriated extremity and is also connected with the ovarian tissue mentioned above by means of the broad ligament, which serves as a mutual bond between tumor, tube and ovarian tissue (see figure). The ligament is normal in appearance, presenting nothing worthy of note. The ovarian tissue which takes part in the composition of the pedicle is smooth, grayish white in color, conical in shape, measuring 3.5 centimeters in length and 2 centimeters at its widest part, where it is attached to and directly continuous with the tumor. Its surface is smooth, free from adhesions and presents a few translucent, cystic follicles 3 to 5 millimeters in diameter.

2. The cyst is purplish in color, 3 centimeters in diameter and has a slender stalk 3 millimeters thick and 2 centimeters long. Its walls are extremely thin and transparent, its contents seen through the delicate walls having the appearance of coffee with milk curds suspended in it.

Over an area 1 centimeter in diameter about the attachment of the pedicle the cyst wall is opaque and 1 millimeter thick. On opening the cyst it is found to have only a single cavity from which a brown fluid containing a white, flaky substance suspended in it escaped.

Sections were taken from the tumor and from the ovarian portion of the pedicle for microscopic examination which showed the former to be composed of interlacing bundles of parallel, wavy fibres with oblong nuclei—the typical picture of fibroma. Areas of hyaline degeneration are seen. The section from the portion of the pedicle supposed from its microscopic appearance to be ovarian tissue is found to be composed mainly of fibrous tissue resembling ovarian stroma. It contains 2 cysts lined with lutein cells in layers of various thickness. No Graafian follicles are seen.

POST-OPERATIVE NOTES. — July 11. Wound dressed. Healed throughout its length, making a fine, linear scar. No sign of inflammation.

July 17. Patient sat up in bed to-day.

July 18. Out of bed in chair one hour.

July 19. Sat up two hours in chair. Feels well and rapidly gaining strength.

July 22. Discharge from hospital in good condition. Color good, feels well and strong. Weight 88 pounds. No cough.

July 28. Came to my office. Has excellent appetite. Breath sounds clear and normal on both sides of chest.

Feb. 28, 1905. Patient came to office to report condition. Now enjoys perfect health and weighs 148 pounds, (a gain of 60 pounds since leaving hospital).

When ovarian fibromata have attained any considerable size ascites is present as a rule and constitutes an important element in diagnosis. It is almost impos-

sible to distinguish fibroma of the ovary from a pedunculated fibroid of the uterus and the presence of ascites might cause one to think there was a malignant tumor or tuberculosis. The difficulties of diagnosis are often so great that a positive conclusion as to the nature of the tumor can be arrived at only by opening the abdomen.

The chief points of interest in this case are the rarity of the tumor, the dangerous complication of torsion of the pedicle of the tumor and the rapid and complete restoration to health which followed its removal.

Fibromata are among the rarest of ovarian tumors, only four cases having been encountered by Kelly in 1200 abdominal sections.

The difficulty of diagnosis of these tumors also lends interest to the detailed account of our case.

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## INTESTINAL OBSTRUCTIONS.

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DR. F. L. POTTS.

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*Mr. President and Gentlemen:*

I desire to report a series of six cases of intestinal obstruction, four of which were due to post operative adhesions; one to the slipping of the bowel through a hole in the omentum, and one to invagination. Symptoms: The symptoms of obstruction regardless of the cause are of course practically the same; previous history only aiding in determining the condition present when following abdominal operation six or eight months or less. There is suddenly developed a severe abdominal pain, early vomiting and absolute constipation are also conspicuous and important symptoms. If the obstruction is high



in the small bowel distressing hiccough may precede vomiting. Except for the possible discharge of the intestinal contents below the seat of obstruction the constipation is usually complete and obstinate. Accompanying the latter condition there is tympanites, which is most marked in obstruction of the colon. Intermittent and colicky at first, the pain soon becomes agonizing and constant, vomiting also alternating with painful retching, is more constant and severe after several hours. The material first ejected is gastric and mucus, it then becomes bilious and finally is characteristically stercoraceous, due most probably to the putrid decomposition of stagnated contents above obstruction. The constitutional symptoms develop early; are intensely threatening to life and cause rapid and profound depression and collapse. The physical examination will discover a swollen and extremely tender and tympanitic belly. *Diagnosis.* That a correct diagnosis should be made at the earliest possible moment is of the utmost importance, as upon this hinges the immediate active treatment. First of all, Ileus must not be confounded with an aggravated tympanites which often gives rise to symptoms like those of intestinal obstruction. In tympanites, however, the general pain is not often paroxysmal in character, the pulse is a little effected, the general condition is not that of profound depression and there is an entire absence of the characteristic facial expression of Ileus. Finally, persistent efforts to produce evacuation of the bowels are followed by copious movement. *Treatment:* While prophylaxis is the most important point in the treatment so far as ileus following abdominal section is concerned, only the active treatment will be dealt with here. As soon as signs of ileus are noted, the efforts must be at once directed towards securing a free movement of the bowels by brisk purgatives. A large dose of calomel is given by mouth and a high enema of soap and water with a dram of turpentine to a pint are given every two hours. To relieve pain stupes of turpen-

tine and hot water are applied. If the sign becomes urgent and there is marked increase in the pulse rate with paroxysmal pains and vomiting stercoraceous, the indications are for immediate operation. *Operative Treatment:* Every precaution must be preserved to prevent shock. Ether I believe to be the best anaesthetic as it is stimulating, especially primarily. The patient should be dressed in warm woolen clothing and the room kept very warm, hot water bottles should be constantly applied to patient's body. Noting as accurately as possible, the position of the supposed obstruction, an incision of from  $2\frac{1}{2}$  inches to  $3\frac{1}{2}$  inches long is made usually down the median line. The intestines are drawn out and laid on or covered in hot gauze and inspected, and under any and all circumstances it is best to be slow in concluding that the ileus is due to a slight twist in the intestines, especially in post operative obstruction. In intussusception all adhesions must be handled with the utmost care and precaution, always very gently applied. If the point of obstruction is not at once found a thorough search from below upward must be made which is usually free from difficulty following the collapsed bowel up to the beginning distention and here finding the obstruction.

#### *Case No. 1.*

Elizabeth S., age 5 years, was first seen by myself in consultation on the 4th day of her illness, temp. 100, pulse 110, respiration shallow and hurried, expression anxious, belly very tympanitic and tender, no tuma palpable. Diagnosis of intussusception was made and immediate operation advised. Patient was prepared in the usual manner—chloroform anaesthetic used. Abdomen opened down median line, digital examination, detected tumor involving ilium which was invaginated about 8 inches and readily reduced. Abdomen was closed without drain, patient made perfect recovery, and was discharged on the 18th day.

#### *Case No. 2.*

J. B., male, age 52, was stricken with a severe attack of colic, two months after

appendectomy, the usual remedies were applied but patient was little benefited. Operation was advised and accepted on the 4th day. Usual preparations made, ether given and an incision  $3\frac{1}{2}$  inches long made midway between symphysis and umbilicus. After a careful search with the index and middle fingers within abdominal cavity nothing could be detected—intestines were now gently lifted out and carefully examined and a twist about midway of the ileum, so judged to be, was found. The examination was continued and no further trouble could be found. Time on table, 40 minutes. Patient's bowels moved on third day, were obstinate on the 5th day, when a large dose of castor oil was given with most happy results. From now on recovery was uneventful and patient was discharged on the 21st day.

#### *Case No. 3.*

Mrs. D. B., 4 months after an ovariectomy begun to notice defecation was incomplete and unsatisfactory and gradually grew worse. This condition lasted six weeks when patient was suddenly taken with severe abdominal pains, rapidly becoming tympanitic, and vomiting fecal matter, expression anxious, pulse 120, temp. 96—operation of course immediately advised—incision of about 3 inches in length was made down the median line, when peritoneal cavity was opened, a pint or more of clear straw colored fluid escaped, on the introduction of two fingers, it was at once discovered that the loop of intestine was adhered to the pedicle of Ovary, noting change in color to the bowel wall and fearing its extreme friability part of the stump tissue was left to the bowel. Before leaving the table she had thorough evacuation and gas escaped in volumes. Patient was discharged on the 31st day.

#### *Case No. 4.*

B. W., male, age 31 years, suffered an attack of appendicitis of four weeks duration, developing what was supposed to be a considerable amount of pus, and in fact, after the sixth day the right iliac

fossa was believed to be full of pus. He refused operation and after three more and long tedious weeks he was able to be up and out, but strength and any degree of comfort was very slowly regained, and at no time could patient straighten up, complaining of a pulling sensation in right side. This went from bad to worse until twelve weeks after first attack when patient was suddenly taken with severe abdominal pains and vomiting, obstinate constipation, which could not or was not overcome. Being familiar with the previous history, operation was advised, ether given and after the usual preparations, an incision of three inches long was made through the rectus muscle. On entering the peritoneal cavity nothing escaped and after a most thorough search the stump of an appendix was found. It has never been my lot before nor since to see so many adhesions. Small bowel to small bowel, and everything to pelvic wall. Incision was closed without drain, recovery was perfect, patient discharged on the 18th day.

#### *Case No. 5.*

Mrs. C. N., age 28, after riding about 18 miles patient partook freely of raw tomatoes and hard boiled eggs, in the course of two hours was suddenly seized with severe abdominal pains and vomiting. The contents of the stomach only were ejected, a hypo. of morphine and atropine was given and repeated in half an hour. Hot applications were applied to abdomen and more morphine given, five grains of calomel and soda followed in 4 hours with eps. salts and a high enema of warm water and soap suds, a tumor could now be easily palpated in the median line midway between umbilicus and symphysis. Ten hours from onset no bowel movement had been secured and an enema of a sat. solution of eps. salts given with no results. Expression was now anxious, pulse rapid and pain considerably relieved. Operation was advised and accordingly done 36 hours after beginning of the attack. The pulse was now 140 and the expression was deathlike, still we believed it our duty to give her the hope of a last chance. Ether



was given and a median incision made. On opening the peritoneal cavity a quart or more of black offensive fluid escaped followed by lumps of well-formed fecal matter. On inspection it looked as though everything was gangrenous. A loop of the ascending colon was found slipped through a rent in the omentum and about 6 inches of gut from this point was gangrenous, and in fact, at one point had sloughed through to the lumen. Resection was done, cavity cleansed as well as possible and coffer dam with central rope drainage was introduced; patient was bandaged and removed from table—she came around from anaesthetic and died in 10 hours. The puzzling point in this case to me was such an extensive gangrenous process within 36 hours from onset of attack.

#### *Case No. 6.*

W. B. O., male, 31st year, consulted me three months after an operation for appendicitis, complained of a painful swollen scar. On examination it was found to be infected and was later opened in the lower half, liberating a considerable amount of pus, which relieved all symptoms and healed nicely. One month from this time, 4 months after original operation, patient was taken with severe colic. Usual remedies given with relief and through bowel evacuation secured. Six weeks from this attack, I was hurriedly called to see him, again on examination, found him suffering from a most acute paroxysmal abdominal pains and severe vomiting. Physical examination revealed a mass just beneath top of the incision. A hypo. of morphine was given followed by complete relief. A large dose of calomel and soda was ordered, to be followed by a dose of castor oil next morning. My second visit found the patient comfortable but no bowel movement had yet occurred. A dose of salts was now given, with enema four hours later if necessary. Patient's general condition was good, on second day every and all means were used to secure bowel movement but to no avail; condition was so very good it was thought best to wait a few hours longer,

in which time hot poultices were used but no more purgatives given. On the morning of the 4th day patient was anaesthetized with ether and an incision of 3 inches in length was made down median line. On entering the peritoneal cavity it was at once discovered that the tumor in the right side was a mass of omental adhesions, a band of which had completely strangulated the ileum, below the strangulation the bowel was perfectly collapsed, and above of course considerably distended. The band and other adhesions were liberated, and the bowel was somewhat stricured at this point, otherwise everything was in normal condition. Incision was closed without drain, recovery was uneventful, and the patient discharged on the 32nd day.

DR. A. H. HAYDEN: Dr. Pott's paper has interested me considerably, and I have noted carefully, I think, everything that he has said. It is such a paper as I had not dreamed of discussing under any circumstances, for surgery is without my practice at the present day. All surgical cases, near Charleston, I send to the City. I am sorry I do not see Dr. Baker, of Charleston, present. He could probably give us a very interesting talk on at least one case of intestinal obstruction I have had in my practice within the past 15 months.

My object in speaking to this paper is this: I note in Dr. Pott's paper that frequent reference is made to abdominal tumor. In the three cases that have come under my observation in the past 15 months, not one of which came to operation, all three patients died. One, a particularly interesting case, Dr. Baker, of Charleston, came up and saw with me. It was a typical case of intestinal obstruction. But in none of these three cases was I, or others who saw them in consultation, able to discover an abdominal tumor. That particular case of interest was diagnosed four or five days after the patient was taken sick,—was sick that long before I was sent for. I lay more stress in the diagnosis of these cases upon facial expression, eructations, vomiting, bowel conditions, than I do abdominal tumor. In that, I think, I am only following the teaching of a great many prominent surgeons throughout the country, and practical experience has led me to believe that with bowel conditions, eructations, vomiting, and particularly the facial expression, are better points for diagnosis than abdominal tumor.

None of those three cases came to operation, and in all of them I was refused post mortem examinations.

One case was a boy of 15 years of age, whom I knew well and saw every day in the year, sometime during the day. He was taken with a so-called colic. His mother treated him about two days, with domestic remedies, and I was sent for the morning of the third day. His expression was typical,—sunken eyes,—the typical facial ex-

pression with colic. Previous diarrhea, and I had no actions to examine, but I asked them to save all actions between then and my next visit. He had no abdominal tumor, and no tympanites, during the whole attack. The patient was advised to go down that afternoon to the infirmary in Charleston. The family refused to send the child down, and I don't remember exactly, but I think the boy lived about 15 days. For ten days after I saw him, with the exception of the first day, there was no bowel action at all. He would get up and go to stool and have a straining, but with no results. I tried to pass a high rectal tube six or eight times, but never did succeed in passing the tube higher than 8 inches. I believe that the obstruction was high up in the rectum, or very low down in the descending colon. The remarkable point about that case is that the boy lived 15 days. On the eleventh day he had a most profuse bowel action, the obstruction became pervious. He craved a lemonade, and I told them to give him anything he wanted. He had it, and that evening he passed two lemon seeds, showing that the obstruction had been removed. I believe that that obstruction was removed through a gangrenous condition.

In two out of those three cases I saw no tympanites, and I found no abdominal tumor.

DR. W. C. BLACK: I have listened to Dr. Pott's paper on intestinal obstruction with a great deal of pleasure. I certainly feel a very great interest in this subject. During my experience in the practice of medicine now covering 18 years, and pretty general surgery for six or eight years, I have had one case of intestinal obstruction. This case occurred three or four years ago. A diagnosis had been made of appendicitis. On opening the belly, it was found to be a case of intussusception. That is the only case I have seen. I have been called twice in consultation in the last year, once in the last three months, to operate for intestinal obstruction, but upon my arrival, or after examining the patients, I did not think an operation was justified and we decided to wait a little longer, and the patients were all right. That is the only one case of idiopathic intussusception I have seen. It seems to me that Dr. Potts has been operating more for adhesions. I have had a good deal of experience in abdominal surgery, and have had some very sad experience following adhesions, but not obstructions. One case I operated on four times. I did the first operation, and did three post operations after that. The patient was operated on in Atlanta in between, making in all five operations. She is living here, and is about the same now. In these cases, post operative cases, I think that a man should study a good deal and watch that case carefully before opening up. It has been my experience, and the experience of surgeons with whose practice I am familiar, that the chances are rather bad for relieving, or curing a patient in adhesions. I think a man should study the case thoroughly and watch it closely before he operates.

DR. ROYSTER: If the Association will pardon me, I shall take occasion to compliment Dr. Potts on his remarkable record of six cases and one death. I don't know of any better record than that. I shall not attempt to discuss the paper in

detail, but simply to call attention to this suggestion in the handling of acute intestinal obstructions, which I have learned from combining the treatment of two other doctors: one a country doctor in New York, and the other the late Dr. Hardin, of Atlanta. We all know that the diagnosis of acute intestinal obstruction is frequently in doubt before operation, as the cases discussed in the papers have attested. We know again that we have to wait three or four hours frequently before making up our minds whether to operate. The diagnosis not only of intestinal obstruction itself, but the differentiation of the varieties of intestinal obstruction. Fecal impactions, for instance; obstruction by the twisting of the gut, or intussusception from obstruction by adhesions, and so on, are very often difficult to distinguish from each other. During this interim, when the diagnosis is in abeyance, the physician can do a great deal by debating these suggestions I will mention. In the seven or eight cases used in that way I have been very much pleased with it. I refer to the use of eserine or hyoscine hypodermically, and the use of alum enemas. The theory of the employment of the two drugs is this: one produces a complete contraction of the bowel, the other produces unusual relaxation. In the case of extended bowel, vomiting, and absence of pain, it is my practice to give a 25th of a grain of eserine salicylate—that is better than the sulphate,—every hour for three days, hypodermically. If the bowel is not entirely distended, and there is pain, instead of sulphate of morphia, I give 1-100 of a grain of hyoscine hydrobromate. In a few hours' time alum and warm water.

In case of fecal impaction your case is cured. In cases due to other causes, it is very much relieved, the belly is put down, and the operation is rendered much safer and easier in its performance. I remember particularly a case of which I wrote up a report, of ileum obstruction by invagination, in which the diagnosis was in doubt. Hyoscine and alum treatment were given, with the result that in three hours the abdomen was emptied, yet the mass was there. I opened the belly and removed the mass,—got a perfectly clean bowel, and no gas. Recovery was complete.

In many cases the bowel has been opened for fecal impaction, which is unjustifiable, unless you are absolutely certain you can exclude that. This treatment absolutely excludes that, and renders a patient much more comfortable for any operative procedures which might be undertaken.

DR. DEAN: I am glad Dr. Royster has spoken about that alum treatment. If quinine will cure chills and fever, alum will move the bowels. It is just as necessary to move the bowels as to make a child vomit in croup. An ounce or two of alum in a gallon or half gallon of water simply solves the question; it does the work. I have n't tried the eserine or hyoscine. I haven't had the necessity for it.

DR. POTTS: In the diagnosis of those six cases, tumor was found in two or three,—three I think. So far as operating for adhesions was concerned, I did that, and I found in each case an adhesion and complete obstruction, which was relieved by relieving the adhesion. I also found that no case of obstruction was due to fecal impaction, but was due to obstruction in the bowel regardless of fecal impaction.



## PHYSIOLOGICAL SALINE SOLUTION : ITS USES AND ABUSES.

L. C. STENNIS, GREENVILLE, S. C.

It is to be regretted that, in the medical profession, as in many others, when a good thing is introduced often the pendulum swings too far, and discredit is thrown upon the thing or method before maturer experience causes it to swing in its proper arc, proving the old Latin axiom to be true, "*In medias res tutissimus ibi.*"

The immortal Lister, when promulgating the principles of aseptic cleanliness of the hands of the operating surgeon and the field of operation, never contemplated the extremes so assiduously taught and practiced by many of his devoted admirers, in the fitting up of operating rooms with automatic Bi-chloride of Mercury spraying apparatuses kept in constant play during an abdominal section, and an external, internal and eternal deluge of the same.

That progressive Georgia surgeon, Robert Battey, never dreamed that his valuable "operation" should ever receive the extravagant claim of the restoration of mental disorders of women, and countenanced by those who had the medical management of institutions where women were confined. That distinguished French scientist, Brown-Sequard, in his modest claim for his "extract," did not presume to proclaim it "an elixir of youth," as it was heralded to a world of despairing victims of "lost manhood." So it has been with normal salt solution. Not many years ago an event happened in New York City, (which many of you will recall), that gave a powerful impetus to its use, both by the profession and the laity. A prominent public citizen, Hon. Abram Hewitt, was wonderfully and speedily restored to life and health by its administration. This episode was, unfortunately, given publicity throughout the continent, without a proper understanding of the case, whereupon, it was ridiculously assumed that salt was an elixir

of life—a cure-all for all diseases and people, sufferers from ills, real or imaginary, actually tortured themselves with the salt treatment. They had heard it gave new life and health to Mr. Hewitt, and they literally crammed themselves with it, or begged their physicians to inject it into their systems. Of course, the foreign physicians who administered it to Mr. Hewitt never intended the public to get the idiotic notion into their heads that it was a life saver under all conditions. Probably Mr. Hewitt was suffering from a loss of saline constituent in the blood, and the treatment, therefore, was clearly indicated. The blood, as you all know, is composed of .6 to .9 per cent. saline matter. If, therefore, by any pathological condition, this saline constituent is lost, the patient dies, but if it is speedily restored by artificial means, life is sustained. Hence we can see in hemorrhage or wasting diarrhoeas, where much serum is lost, the treatment would be indicated, also in those weakened conditions where normal metabolism is inhibited, or perverted nutrition exists.

In cases of infectious diseases, especially septicemia, these injections seem to wash the blood of impurities. In cases of shock, it stimulates the heart, and is said to be useful in uremic and diabetic coma and eclampsia. It dilutes and eliminates toxic conditions of the blood. The Journal of American Medical Association, Nov. 26th, p. 1,630, '04, gives an interesting account of a case of Rheumatism, which was treated with Salt Solution, after a calomel and saline purgation, and the extraction of 12 oz. of blood by venesection. Before the injection of 2 pts. of the Solution, under the skin, the temperature was 103, pulse 96. The right shoulder, knee, wrist and ankle joints were swollen and painful, and in two hours all pain, except a slight soreness, had disappeared, temperature dropping to normal and pulse to 80. Four months later no recurrence. This patient was a sufferer for years—the last recurrence having lasted four months. This improvement, in my judgment, was the result of a thorough elimination of toxic material by

purgation and bleeding, and a renewal of proper constituent for a supply of new blood for the toxic on hand.

While we should be proud in the possession of so simple and yet so powerful a remedy, still we are mindful of the fact, that when used indiscriminately and empirically, much damage may be done, and this leads me to speak of some of the conditions when it would be contra-indicated. Where arterial elasticity has been changed or lost, as in arterio-sclerosis, and capillary fibrosis, we can readily see the danger from heart stimulation and increased volume of blood, or in conditions favoring internal hemorrhage from heart stimulation. In hyperchloridia and Bright's disease, where the kidneys become more or less impermeable, and, therefore, incapable of elimination; and in all cases where there is enough salt for physiological needs, and more than this will not be tolerated by the system.

Now a word as to the preparation of this solution, and I am done. Those of you who have had adequate training in physiological laboratories know how important it is to prepare these solutions accurately, while many others, like myself, who have not had these advantages, have been content with slipshod methods, sometimes getting good results, but oftener meeting with disappointment. Through the experiments and investigations of Sidney Ringer, of London, first, and later of Loeb, Howell and Locke, it has been proven that not only a correct percentage is essential in the matter of salt, but the addition of small quantities of Calcium Chloride and Potash Chloride, is helpful for the following reasons: viz., that the Calcium is stimulating agent to the heart and muscle, and that potassium is essential to its rythmical contraction and relaxation. For these reasons, and upon the suggestion of Dr. F. S. Locke, of the Physiological Department in Howard Medical School, and Dr. Hobart A. Hare, Professor of Therapeutics in Jefferson College, a large and reputable manufacturing establishment, gets out a concentrated Saline Solution for the use of the profession with this formula:

Calcium Chloride, 0.25 grm.

Potassium Chloride, 0.1 grm.

Sodium Chloride, 9.0 grm.

Sterilized water 100 q. s. one Litre

Dose ranges from  $\frac{1}{2}$  to 1 litre, and the frequency of the injections varies according to the exigencies of the case. Every physician's case should be supplied with this, and cease to depend upon the old method, "1 tea-spoonful to a quart."

DR. MANNING SIMONS.—I expect all of us will agree with Dr. Stephens in the remarks contained in the first sentence of his paper, namely, that the tendency in all departments of medicine and surgery is to run into extremes. It is only necessary for a new operation, or a new application of an old operation to be announced in surgery, for everybody to do it; to do it with judgment and without judgment. These remarks apply equally to the use of the normal salt solution, as it is familiarly called. This brings me to say that judgment is one of the most important things that we have in our armamentarium in the practice of medicine, and there must be judgment exercised in the application of any surgical procedure as well as the application of any method of treatment which may be presented for our use. But of all the things lately offered to us in surgery, normal salt deserves to take a high place. We find the indications for it to be stated in very few words,—shock, hemorrhage, septicemia,—these are the indications for which we find the application of normal salt solution most frequently. Anyone who has been brought face to face with great hemorrhage will bear me out in saying that its value must be appreciated. Only recently I had the opportunity to see its value in the form of hypodermoclysis. A man was brought into the hospital with a stab in the neck, the knife passing between the subclavian vein and artery, cutting the former artery and into the plural cavity. He lost a great quantity of blood before he was brought to the hospital, and I found him almost pulseless. It seemed as if he was going to die before he could be placed on the operating table. Blood was still oozing from the wound. Whilst I was enlarging this wound, the dangerous neighborhood of which is familiar to all of you, an injection of a pint of normal solution containing 30 drops of adrenalin solution and 1 oz. of whiskey was injected in his right arm. The effect was remarkable.

But I have had in its use another of the most powerful agents which have been presented to us for shock. In these injections under the skin and in the rectum. I add to the salt solution 30 drops Adrenalin and an ounce of whiskey. This is used under the skin, or the same combination in the rectum. Under such conditions there is hardly one present who would gainsay the value of normal salt solution. In shock its value is appreciated by all surgeons to-day, and it has actually become a matter of routine practice to those who have to operate often, to give normal salt solution and whiskey before the patient is removed from the table, and in cases of extreme shock we make use of repeatedly at longer or shorter intervals until reaction is secured.



Now we come to a very important use of it, in cases of blood poisoning, in cases of suppurative appendicitis and septic peritonitis following appendicitis. We have had this particularly brought to our attention by Ochsner, Fowler and Murphy and others. With the position of Ochsner, raising the patient in bed to an angle of 45 degrees, so that gravitation will take place into the pelvis the seeping in of this salt solution, is valuable. To take the results of such men as Ochsner, Murphy and others by this method of treatment, it is marvelous to those of us who have had bad results in these cases,—and such bad results have been common to all of us in cases of septic peritonitis following suppurating appendicitis. In making use of normal salt solution for this purpose. Murphy calls particular attention to the fact that it must be seeped in, the fluid allowed to go in little by little, until absorbed in small quantities; absorption is necessary in order to get the good effect of the solution under those circumstances.

DR. STEPHENS.—Since writing my paper I received a little pamphlet from Dr. Burroughs, who gave me some very interesting experiments with salt solution, and which would have been incorporated in the paper if received in time. He happens to get his mechanical method from Dr. Murphy, in injecting gas into the lungs.

In 17 cases he reports gratifying results where he had injected this salt solution into the pleural cavity, and I suppose it acted both ways, both by pressure, and by its advantages in shock. He mentions one case especially, where three pints of blood were in the jar, in a hurry call to a patient, and he found that with one injection of this solution, the hemorrhage checked up.

He also relates 83 cases in which he tried experimenting with pleuritis, in tuberculosis, and he said he had gratifying results in all cases but 6. In one he burst the membrane of the pleura, and came very near, and did drown the man, I suppose,—the solution did,—he died anyway.

I think those are interesting cases and ought to be known. Hardly a journal you take up these days but what you find it applied to some new kind of treatment, and it would not surprise me if in ten years, or less time than that, it would be used in the general affections associated with skin lesions, such as smallpox, measles, etc. If it will cure septicemia, would it not be applicable to other troubles found in the blood?

### THE GREENVILLE MEETING.

That the Greenville meeting was a grand success no one will gainsay. The attendance was high water mark for the South Carolina Medical Association, and the meeting marks an epoch in the history of our Association that will stand against all time.

It was the first meeting conducted under the new constitution; and, while there were several minor points in the constitution that required mature deliberation at the time. President Wilson is to be congratulated upon his wise decisions in these emergencies, and in the display of real parliamentary genius upon all points of vital welfare to the Association.

Several times during the past five years has the medical ship of State encountered storms

that threatened to engulf her, but each time has the man at the helm risen to the occasion and guided our fair ship into smooth waters.

Our experience at Florence, at Sumter, and recently at Greenville, should impress indelibly upon us the importance of selecting strong men for the chair—men of unquestioned ability, and preferably of parliamentary ability. In such a large body of men, as our Association is getting to be, occasions are bound to arise which require strong men to meet them, and the stronger the better.

The simplicity of the workings of our new constitution must impress those familiar with it, and after a session or two of getting the machinery into shape and oiling certain unseen bearings, we feel satisfied that as a complex whole it will be "a thing of beauty and a joy forever."

Everyone who attended the general session must have noticed how easily that portion of our meeting transacted a large amount of work, without the friction and jars of business intervention which were so characteristic of previous meetings. And, likewise, those attending the House of Delegates must have taken cognizance of the greater facility, and thoroughness with which a small body of men can handle the business portion of our sessions.

The social portions of the meeting were numerous, replete and successful from every point of view, and conflicted slightly, if at all, with the general and business sections.

The Greenville meeting will live long in the memory of those in attendance.

### PROCEEDINGS OF THE HOUSE OF DELEGATES.

#### FIFTY-SEVENTH ANNUAL MEETING OF THE SOUTH CAROLINA MEDICAL ASSO- CIATION.

Greenville, S. C.

The House of Delegates met at 2:00 P. M., Tuesday, April 11th, 1905, in the Rooms of the Board of Trade. Owing to the expected arrival of other delegates, organization was on motion postponed and adjournment taken to 4:00 P. M.

The house was called to order at 4 o'clock by the President, Dr. Robert Wilson, Jr., of Charleston.

The President stated that as no election had been held for the Council, in accordance with the new Constitution, at the Darlington meeting, he had divided the State into Councillor Districts and made the following temporary appointments:

1st. Charleston, Colleton, Beaufort, Berkeley, Dorchester and Hampton.

Dr. E. F. Parker, Charleston.

2nd. Aiken, Orangeburg, Bamberg, Barnwell and Lexington.

Dr. T. G. Croft, Aiken.

3rd. Newberry, Edgefield, Saluda, Abbeville, Greenwood and Laurens.

Dr. O. B. Mayer, Newberry.

4th. Greenville, Spartanburg, Union, Anderson, Oconee and Pickens.

Dr. J. W. Jervey, Greenville.

5th. York, Cherokee, Chester, Fairfield, Lancaster and Kershaw.

Dr. R. A. Bratton, Yorkville.

6th. Florence, Chesterfield, Darlington, Marlboro, Marion and Horry.

Dr. F. H. McLeod, Florence.

7th. Sumter, Georgetown, Richland, Clarendon and Williamsburg.

Dr. Walter Cheyne, Sumter.

Dr. T. P. Whaley, Dr. O. B. Mayer and Dr. J. L. Napier, appointed Committee on Credentials, made the following report of delegates in attendance, which was verified on roll call of Counties.

Abbeville: Dr. J. R. Bell, Due West.

Aiken: Dr. H. Wyman, Jr., Aiken; Dr. W. D. Wright, Langley.

Anderson: Dr. W. R. Dendy, Pelzer; Dr. R. G. Witherspoon, Hollands.

Bamberg: No delegate.

Barnwell: Dr. E. L. Patterson, Barnwell.

Beaufort: No delegate.

Berkeley: No delegate.

Charleston: Dr. A. Johnson Buist, Dr. T. Grange Simons, Charleston.

Cherokee: Dr. J. P. Young, Richburg; Dr. H. E. McConnell, Chester.

Chesterfield: No delegate.

Clarendon: No delegate.

Colleton: Dr. J. T. Taylor, Adams Run.

Darlington: Dr. G. B. Edwards, Darlington.

Dorchester: Dr. J. B. Johnson, St. George.

Edgefield: Dr. R. A. Marsh, Edgefield.

Fairfield: No delegate.

Florence: Dr. James Evans, Florence.

Georgetown: Dr. W. E. Sparkman, Georgetown.

Greenville: Dr. W. C. Black, Dr. G. T. Swandale, Greenville.

Greenwood: Dr. S. L. Swygert, Greenwood.

Hampton: Dr. W. B. Monsen, Luray.

Horry: No delegate.

Kershaw: Dr. A. A. Moore, Camden.

Lancaster: No delegate.

Laurens: Dr. J. G. Miller, Cross Hill; Dr. T. L. W. Bailey, Clinton.

Lee: No delegate.

Lexington: Dr. W. P. Timmerman, Timmerman's.

Marion: Dr. E. M. Dibble, Marion.

Marlboro: Dr. J. L. Napier, Blenheim.

Newberry: Dr. W. G. Houseal, Newberry.

Oconee: Dr. E. A. Hines, Seneca.

Orangeburg: No delegate.

Pickens: Dr. W. A. Trippe, Easley.

Richland: Dr. A. B. Knowlton, Dr. J. H. McIntosh, Columbia.

Saluda: Dr. J. D. Waters, Coleman.

Spartanburg: Dr. Geo. R. Dean, Dr. H. R. Black, Spartanburg.

Sumter: Dr. S. C. Baker, Sumter.

Union: Dr. M. W. Culp, Union.

Williamsburg: No delegate.

York: Dr. M. J. Walker, Yorkville.

#### COUNCILLORS:

Dr. E. F. Parker, Charleston, First District.

Dr. T. G. Croft, Aiken, Second District.

Dr. O. B. Mayer, Newberry, Third District.

Dr. J. W. Jervey, Greenville, Fourth District.

Dr. R. A. Bratton, Yorkville, Fifth District.

Dr. Robert Wilson, Jr., President; Dr. T. P. Whaley, Charleston, Secretary; Dr. C. P. Aimar, Charleston, Treasurer, *Ex Officio*.

A quorum being present, the chair declared the House duly organized and ready for business.



After some discussion, the per capita fee to be paid the State Association by County Societies for each member was fixed at \$3.00 per year.

On motion the Secretary was instructed to issue charters to each County Society applying for charter, to be delivered upon payment of the proper fees.

The chair was asked for a ruling on relation of physicians in Counties where there was no County organization to the State Association. Held: That such physicians might apply for membership in the nearest County Society, as under the new Constitution only members of County organizations can be members of State Association.

Reading of minutes of previous meeting dispensed with on motion, having been published in annual transactions.

TREASURER'S REPORT.

The Treasurer submitted the following report, which was on motion received as information and ordered spread on the minutes:

*To the President and Members of the South Carolina Medical Association:*

GENTLEMEN:

I have the honor to submit the following report:

SUMMARY.

Balance cash on hand April 18,	
1904 .....	\$284.86
Cash collected April 18, 1904,	
to April 9, 1905 .....	836.50
Total .....	\$1,121.36

EXPENSES.

Expenditures from April 18,	
'04, to April 9, '05 .....	\$859.14
Balance cash in bank .....	\$262.22

Respectfully submitted,

C. P. AIMAR, M. D., *Treasurer.*

SECRETARY'S REPORT.

Dr. Whaley: It has not been customary for the Secretary to submit a written report. I would say that the business

of the Association has greatly increased during the past year. I have not had reports yet from all the County Societies, but their organization has progressed satisfactorily, largely aided by Dr. McCormack's visit through the State. We have now 385 members enrolled, with a number of Societies to hear from.

A letter from Dr. McCormack was read by the Secretary, stating his opinion on the conditions in the State.

REPORT OF SCIENTIFIC COMMITTEE.

Dr. T. Grange Simons: Several members of the Committee interested themselves, and fifteen letters were written requesting members to prepare papers. Only two answers were received, both declining to write on the subject selected.

REPORT OF COMMITTEE ON PUBLIC POLICY AND LEGISLATION.

Dr. Robert Wilson: As one of the members of that Committee I would say that we had nothing before us but to support and sustain the State Board of Health in their claims before the Legislature. The Chairman of your Committee went before the Committees of the House and Senate and did what he could in bringing before them the necessity for the passage of certain laws suggested by the Board of Health.

REPORT OF STATE BOARD OF HEALTH.

Dr. T. Grange Simons: We will submit later a written report. We are very much encouraged. This year for the first time the Legislature heard our requests with any degree of tolerance even. We went before the Committees on Finance and Medical Affairs, and succeeded in having measures passed which must give security to communities, and will in time reduce the existence of epidemic diseases materially in this State. We were handicapped in the battle with smallpox by the insufficient funds allowed by the Legislature, and the lack of authority to enforce preventive measures. Under the compulsory laws now passed, and with a better knowledge of the profession in each County under our organization, we can

accomplish more in the effort to suppress smallpox. The expense will be borne by the Counties, but our Board is to direct how those expenditures shall be made, and we select some well-known physician in any community where it is reported, and everything will be under his direction. The Attorney General is here, and will meet with us to-night to assist us in perfecting measures by which we hope to change materially the aspect of things in South Carolina.

#### REPORT OF STATE BOARD OF EXAMINERS.

Dr. Napier: In the absence of the Secretary of the Board, I will say that at last we have gotten the law as we want it. It changes the meeting to the second Tuesday in June, and changes the fee from \$5.00 to \$10.00. An appropriation was also made to defray the expenses of the Board, which has not been done heretofore. A fuller report will be made later.

#### REPORT OF COUNCILLORS.

##### *First District.*

Dr. Parker: Of the Counties in my District, there was already in Charleston, as you all know, a well organized Society, existing for a number of years. In Dorchester there was also a well organized Society, probably one of the best organized in the State. For several years they have held regular meetings, and have invited their neighbors to meet with them and read papers or make addresses.

I visited Hampton and organized a Society there, of which the Secretary has a report.

I visited Beaufort and perfected an organization there very successfully.

At Walterboro, in Colleton County, I met with moderate success. The Secretary has these reports.

The only County I did not organize in was Berkeley, in which there are only five or six physicians, and those living very far apart. Upon personal conference with each one, all expressed a preference for joining the Society of some neighboring County, and upon consultation with President Wilson we deter-

mined it would be better to defer organization in Berkeley for another year at least.

##### *Second District.*

Dr. Croft: I have succeeded in organizing four out of the five Counties in my District.

Lexington was organized with Dr. W. P. Timmerman as President.

Aiken has an excellent Society, with some 20 odd members.

Barnwell and Bamberg were organized and have reported to the Secretary.

In Orangeburg I have not been able yet to organize, but before the next meeting we will no doubt have an organization there, though the County has not yet shown much enthusiasm.

##### *Third District.*

Dr. Mayer: All the Counties in my District have been organized and have very good Societies. The profession is very well organized in all these Counties, the Societies averaging a membership of 15.

##### *Fourth District.*

Dr. Jervey: On January 14th I visited Union, at the request of the President of the County Society, and found that there had been a great deal of dissension in that Society at one time on account of charges brought against a member in the Association. I found it utterly impossible to get any recognition for the member resting under the charges. I called for a rising vote of the Society and every member rose to corroborate the previous action of the Society in the expulsion of the member. I found the Society in splendid condition,—one of the best in this District,—with a membership of about 20, and they have made application for charter.

On February 11th Dr. J. W. McCormack visited us and we had between 30 and 35 in attendance on the meeting. The District has shown benefit from his visit. Since then every County has been organized and is now in working order.

I visited Easley, Pickens County, on March 13th, and out of a total of 16 phy-



sicians in the County, 10 were present and signed the roll and application for charter. Since then, I believe, 5 others have signed the roll.

On March 17th I visited Spartanburg. Out of a total of 55 or 60 physicians in the County, 35 were present and signed the roll. Since then, I believe, several members have been added to the list.

On March 27th I visited Anderson. I don't know the number in the County, but we enrolled at the time 26 members.

Seneca, Oconee County, I visited March 25th, and there were 14 of the physicians in the County either present, or having given authority to others present to sign the roll for them.

Greenville County had reorganized before I started on my mission to assist in the other Counties, and they now have a membership of about 35 out of a total of about 50 in the County.

I find in some of the Counties that practitioners who have evaded the State law as to examination by the State Board are endeavoring to get into the County Societies. We should like to have some ruling from the House of Delegates on the standing of those physicians who claim to be regular practitioners because of having practiced for five years under County registration.

#### *Fifth District.*

Dr. Bratton: I have been unable to visit all the Counties in my District. We have as yet no results in Lancaster and Fairfield. York, Chester and Kershaw are fairly well represented.

We have been unable to analyze the Code of Ethics and Constitution to fit the County Society, and we have had trouble with the matter of fees to the Association. I hope these matters will be settled here.

#### *Sixth District.*

Dr. McLeod: Absent. No report received.

#### *Seventh District.*

Dr. Cheyne: Absent. (Read by Sec'y later.)

#### REPORT OF COMMITTEE ON NECROLOGY.

Saluda County: Dr. Walters reports death of Dr. J J Buster, Mt. Willing, and Dr. A. S. Ashley, Fruit Hill.

Georgetown: Dr. Sparkman reports death of Dr. T. P. Bailey, and submits resolutions.

Dr. Mayer moves that the resolutions be adopted and a copy thereof mailed to the family of the deceased. Carried.

Motion to reduce the number of the Committee on Necrology was defeated.

Dr. Jervey suggested that the arrangement of the State into Councillor Districts be changed. Referred to Council.

On motion of Dr. T. Grange Simons the Secretary was instructed to request the State Board of Medical Examiners to examine into the law and report to this body on the legal status of physicians claiming to be regular practitioners because of five year County registration.

An invitation was accepted from the Faculty and Students of Chicora College to a reception to be held at 8:30 this evening in compliment to the Association.

The following physicians, having held membership in the Association for thirty years and over, were unanimously elected to honorary fellowship in the Association:

Dr. T. G. Croft, 1875; Dr. M. G. Salley, 1873; Dr. R. L. Brodie, 1873; Dr. Manning Simons, 1875.

A letter from the Tri-State Society of Ala., Ga. and Tenn. to Dr. Wilson was read and reserved as information.

On motion the House adjourned until 9 o'clock Wednesday morning, April 12th.

Wednesday morning, April 12th.

The House was called to order at 9 o'clock by the President, a quorum being present.

On motion of Dr. Culp, seconded by Dr. Timmerman, it was resolved that no appropriation be made for the expenses of a delegate to the meeting of the American Medical Association, to be held in Portland, Oregon.

A motion to reconsider the action of

the House in fixing the per capita tax to be paid by County Societies at \$3.00, and fix the same at \$2.00, was withdrawn after discussion.

There being no further business at this time the House adjourned to 8:30 P. M.

Wednesday evening, April 12th.

The House was called to order by the President at 8:30 P. M., a quorum being present.

On motion of Dr. A. J. Buist the recommendations contained in the President's Address, delivered before the general meeting, were taken up for discussion.

Secretary Whaley stated that in consultation with the President and Treasurer he had looked into the matter of publication of a journal, and had ascertained that a journal of 30 to 33 pages could be published and delivered to each member monthly at a cost of about \$1,000 per annum. Letters were read from the various State Associations publishing monthly journals, stating that it was of great assistance in keeping the organizations intact, and was but little more expensive,—in some instances less,—than the cost of publishing annual transactions in book form. The Secretary stated that there was a reasonable expectation of \$500.00 per year from advertising, and as the editor would be expected to serve without compensation the cost would be but little more than the cost heretofore of the annual transactions. The idea is to publish all minutes of meetings and scientific papers in the journal, with transactions of County Societies, and all official announcements, with preliminary and final programmes of meetings, thereby saving expense of printing and postage. The purpose is to give to each member of the Association a good medical journal without other cost than the fee paid to the State Association for membership.

After further discussion a motion to authorize the publication of a journal was unanimously carried, to be under the direction of the Council.

Dr. Robert Wilson, Jr., of Charleston,

and Dr. T. P. Whaley and Dr. C. P. Aymar of Charleston, were unanimously recommended to the Council for election as Editor and Associate editors respectively.

Dr. A. B. Knowlton gave notice of amendment to the Constitution, for consideration at next meeting, to allow representation in the House of Delegates to the State Board of Medical Examiners and State Board of Health by making the chairman of each Board *ex-officio* members of the House of Delegates.

On motion of Dr. Timmerman the President was requested to appoint a committee of five to look into the matter of proprietary and patent medicines and report back to this Association at the next annual meeting.

On motion of Dr. Mayer the President was authorized to appoint a committee to be composed of one member from each County Society, to be known as the Committee for the Study and Prevention of Tuberculosis.

A long discussion was held to devise some feasible means for the prosecution of illegal practitioners throughout the State.

On motion the matter was referred to the Council, with instructions to proceed, by raising the necessary funds by voluntary contributions and soliciting subscriptions, and employing a lawyer to start the prosecution in every case reported to the Council by the County Societies.

On motion of Dr. Napier delegates were instructed to bring this matter before their County Societies and proceed to raise funds for this purpose, to be sent to the Treasurer as soon as possible.

On motion of Dr. S. C. Baker a recess of five minutes was granted, and voluntary subscriptions amounting to \$96.00 were handed to the Treasurer as a nucleus for the prosecution fund.

On motion Dr. Baker was requested to bring the matter before the general meeting on Thursday and call for subscriptions.

The Secretary reported that the Society had been without a seal for several years, and it was now necessary to have an of-



ficial seal. On motion, Dr. Robert Wilson, Jr., the Secretary and Treasurer, was authorized to select and purchase a suitable and appropriate seal.

Dr. Culp moved that the House proceed with the selection of a place of meeting for 1906. Invitations were received from Columbia, Chester, Bennettsville, Georgetown and White Stone Springs. Columbia received a majority vote on the third ballot and was declared the place of meeting for 1906.

On motion the House adjourned, subject to call of the President.

#### THURSDAY, APRIL 13th.

The House met at one o'clock on call of the President, with a quorum present.

On motion of Dr. Timmerman the third Wednesday in April was selected as the time for the meeting to be held in Columbia in 1906.

#### ELECTION OF OFFICERS.

The President announced that election of officers was in order, and called attention to the fact that under the Constitutional members of the House of Delegates were not eligible to office, except members of the Council to re-election, and the President, Secretary and Treasurer, who were members *ex-officio*.

Nominations were made from the floor, and the election held by ballot, resulting as follows:

President: Davis Furman, M. D., Greenville.

1st V.-P.: S. W. Pryor, M. D., Chester.

2nd V.-P.: Crown Torrence, M. D., Union.

3rd V.-P.: D. B. Frontis, M. D., Ridge Springs.

Secretary: T. P. Whaley, M. D., Charleston.

Treasurer: C. P. Aimar, M. D., Charleston.

#### COUNCIL.

1st District: Dr. E. F. Parker, Charleston, for 3 years.

2nd District: Dr. T. G. Croft, Aiken, for 1 year.

3rd District: Dr. O. B. Mayer, Newberry, for 3 years.

4th District: Dr. J. W. Jervey, Greenville, for 3 years.

5th District: Dr. R. A. Bratton, Yorkville, for 2 years.

6th District: Dr. F. H. McLeod, Florence, for 1 year.

7th District: Dr. M. P. Moorner, Georgetown, for 2 years.

#### STATE BOARD OF MEDICAL EXAMINERS.

1st District: Dr. W. P. Porcher, Charleston.

3d District: Dr. O. B. Mayer, Newberry.

5th District: Dr. R. A. Bratton, Yorkville.

7th District: Dr. S. C. Baker, Sumter.

Dr. Jervey gives notice of Constitutional amendment to be acted upon at next meeting, to provide that members of State Board of Medical Examiners shall not be eligible to re-election after a two year term.

On motion of Dr. Mayer the salary of the Secretary of the Association was fixed at \$125.00 per annum.

On motion of Dr. Simons the compensation of the Treasurer was fixed at ten per cent. of all collections, with allowance of actual expense incurred attending annual meetings.

On motion of Dr. Culp, a vote of thanks was tendered Dr. Robert Wilson, Jr., retiring President, for the able and impartial manner in which he has presided.

On motion of Dr. Mayer, a vote of thanks was extended to the faculty and students of Chicora College, the faculty and students of Greenville Female College, the entertainment committee of the Greenville County Society, the Street Railway Company and the citizens of Greenville for courtesies extended the members of the Association during the meeting.

On motion of Dr. Swygert the Committee on proprietary and patent medicines were requested to take up with the State Pharmaceutical Association the

matter of "counter prescribing" by pharmacists.

Their being no further business the meeting adjourned.

## PROCEEDINGS OF THE GENERAL MEETING.

WEDNESDAY, APRIL 12th.

### MORNING SESSION.

The Fifty-Seventh Annual Meeting of the South Carolina Medical Association was called to order at 10:30 a. m., Wednesday, April 12th, 1905, by President Robert Wilson, Jr., M. D., in the Auditorium of Chicora College, Greenville, S. C.

After an opening prayer by Rev. Dr. E. M. Poteat, addresses of welcome were made by Mayor G. H. Mahon, in behalf of the City of Greenville, and Dr. T. T. Earle, in behalf of the Greenville Co. Medical Society.

The President, Dr. Wilson, responded in behalf of the South Carolina Medical Association.

Dr. H. A. Royster, of Raleigh, N. C., was introduced to the Association by the President, and on motion the privileges of the floor and of discussion were extended Dr. Royster and all other visiting physicians.

Invitations were read from the Greenville Female College for a reception tendered the Association on Thursday evening, April 13th, from 8 to 9:30 o'clock.

Also from the Elks' Club, to make use of their Club Rooms while in the City.

On motion, the invitations were accepted with thanks.

### READING OF PAPERS AND DISCUSSION.

President Wilson: Under the new Constitution all business matters are disposed of by the House of Delegates, and the sole purpose of these meetings is to dispose of the scientific program.

Paper read by Dr. F. L. Potts, of Spartanburg, "Six Cases of Abdominal Obstruction." Discussed by Dr. A. H.

Hayden, Dr. W. C. Black, Dr. Royster, Dr. Dean.

Paper read by Dr. J. W. McCanless, of Chesterfield, "The Therapeutic Indications of Ergot, other than Obstetrical." Discussed by Dr. E. A. Hines, Dr. A. H. Hayden, Dr. C. P. Aimar.

### PRESIDENT'S ADDRESS.

At 12 M. Vice-President W. C. Black was called to the chair, and President Wilson read the Annual Address.

At the conclusion of the President's address, on motion, a vote of thanks was extended Dr. Wilson, and the address referred to the House of Delegates with the approval of the General Meeting.

The President having resumed the chair, the meeting on motion adjourned to 3:30 p. m.

### WEDNESDAY AFTERNOON, APRIL 12TH.

Meeting called to order at 3:30 p. m. by the President.

Paper read by Dr. L. C. Stephens, of Greenville, "Physiological Salt Solution: Its Uses and Abuses." Discussed by Dr. M. Simons.

Paper read by Dr. W. P. Porcher, of Charleston, "Rest in the Treatment of Laryngeal and Pulmonary Tuberculosis." Discussed by Dr. A. H. Hayden, Dr. H. Wyman, Jr.

Paper read by Dr. J. W. McCanless, of Chesterfield, "The Physician from a Philanthropic Aspect and as a Member of Society." Discussed by Dr. A. H. Hayden, Dr. J. T. Taylor, Dr. L. Mullally, Dr. S. L. Swygert, Dr. D. M. Crosson.

Paper by Dr. C. M. Rees, Charleston, read by title, "Surgery of the Kidney,—Report of Cases."

Paper read by Dr. LeGrand Guerry, of Columbia, "Appendicitis." Discussed by Dr. C. B. Earle, Dr. T. P. Whaley, Dr. A. B. Knowlton, Dr. S. C. Baker, Dr. A. H. Hayden, Dr. Royster.

On motion, the meeting adjourned to Thursday morning, 10:30 a. m.

### THURSDAY MORNING, APRIL 13TH.

Meeting called to order at 10:30 a. m. by the President.



Paper read by Dr. E. L. Patterson, of Barnwell: "Report of a case of Herniotomy, and a case of Laparotomy for Lacerated Abdominal Wound." Discussed by Dr. Monsen, Dr. M. Simons, Dr. W. P. Porcher, Dr. F. Julian Carroll.

Paper read by Dr. Manning Simons: "Gastrostomy for Stricture of the Esophagus, with illustrative case." Discussed by Dr. Royster, Dr. E. L. Patterson.

Paper read by Dr. H. R. Black, of Spartanburg: "Foreign Bodies in the Larynx, Trachea and Bronchi, with report of Cases." Discussed by Dr. C. M. Walker, Dr. D. M. Crosson, Dr. Monsen, Dr. W. P. Dendy, Dr. Porcher, Dr. Whaley, Dr. G. B. Edwards.

Clinical Presentation: A Case of Complete Double Congenital-Capsular Cataract. Accepted as incurable at the State Institution for Deaf, Dumb and Blind, at Cedar Springs, S. C., operated upon at Twelve years of age with Most Gratifying Results. By Dr. J. W. Jervey, of Greenville. Discussed by Dr. Horlbeck, Dr. Porcher and Dr. Monsen.

Paper read by Dr. A. B. Knowlton, of Columbia: "Gall Stones."

Paper read by Dr. A. J. Buist, of Charleston: "Aneurism of the Groin: Report of a Case." Discussed by Dr. M. Simons, Dr. Royster.

Paper read by Dr. Lane Mullally, of Charleston: "Puerperal Eclampsia."

Paper read by Dr. R. S. Cathcart, of Charleston: "Should the Radical Cure of Hernia be Attempted by Median Abdominal Section?"

Papers read by title:

"Fractures of every Limb—Amputation—Recovery," Dr. M. J. D. Dantzler, Elloree.

"Retro-displacements of the Uterus," Dr. A. E. Baker, Charleston.

THURSDAY AFTERNOON, APRIL 13TH.

Meeting called to order at 3:30 p. m. by the President.

President Wilson: We have the unusual honor of having with us the head of the Medical Profession in the United States. I have the pleasure of introduc-

ing to you Dr. J. H. Musser, of Philadelphia.

Dr. Musser then delivered the Annual Address.

On motion of Dr. Jas. Evans, a vote of thanks was extended Dr. Musser for his exceedingly interesting address.

Dr. Whaley: I move that Dr. Musser be elected to honorary membership in this Association.

President Wilson: This is not the house for business, but I will overrule the Constitution and put that motion. Motion unanimously carried.

Dr. Musser: The honor you have conferred upon me, gentlemen, is one that I most highly appreciate.

Vice-President Black was then called to chair.

Paper read by Dr. E. A. Hines, of Seneca: "Pediatrics: Past, Present and Future." Discussed by Dr. T. G. Simons, Dr. D. B. Frontis, Dr. J. T. Taylor, Dr. Timmerman.

The scientific program having been disposed of, except such papers as were to have been read by members unavoidably absent, Dr. R. A. Lancaster, Dr. T. Grange Simons and Dr. W. P. Timmerman were appointed a committee to present the President elect for installation.

Vice-President Black: Gentlemen of the Association, I take great pleasure in introducing to you your newly elected President, Dr. Davis Furman, of Greenville, who I am sure will fill this office with credit to himself and honor to the Association.

DR. FURMAN: Gentlemen: No words could express my sincere thanks for the honor you have conferred on me. I don't think any one could have been more surprised than I was when notified that I had been made President. I thought you would have selected another and a better man, and that I would have the privilege of taking a back seat and enjoying what was going on without the natural timidity I feel in getting up before such an audience. With the reorganization, there will be a great deal of additional work thrown on the President, as there has been in the past year. I hope I shall have

the hearty co-operation of every member of the Association in the performance of the arduous duties that I feel are before me.

There being no further business, the meeting on motion adjourned at 5:30 p. m.

#### MINUTES OF THE MEETING OF THE COUNCIL, APRIL 13, 1905.

Immediately after the adjournment of the S. C. Medical Association, the Councilors met, as provided by the By-Laws, Dr. O. B. Mayer, Chairman, and passed the following resolutions:

I. That each councilor take charge of his district and do all in his power to build up in his county societies, and eradicate quacks, etc.

II. That while each Councilor shall use his best judgment in his own district, Councilors shall aid each other, when necessary, in the process of prosecutions.

III. The county first taking up the prosecution of quacks and irregulars may be entitled to the benefit of the fund raised for that purpose by the members of the State Association. This to be determined by the Council.

IV. That Dr. E. F. Parker be a committee of one to audit the Treasurer's accounts.

Respectfully submitted,  
R. A. BRATTON, Clerk.

#### COMPULSORY VACCINATION.

Rules of the Board of Health in regard to Enforcing Vaccination according to an Act of the General Assembly, approved Feb. 22nd, '05, No. 434.

To Local Boards of Health, Boards of County Commissioners, Superintendents, Principals and Boards of Schools and Institutions of Learning, Parents, Guardians, and Others, Charged with the Responsibility for any Child; Mayors, Intendants, and Members of Municipal Governments, and all Other Persons Charged with any of the Duties Hereinafter set forth:

Take Notice: That the following rules which by reference to the Act referred to and hereinafter printed it will be observed, have the force and effect of law.

At a meeting of the State Board of Health on

the 12th day of May, 1905, by virtue of An Act of the General Assembly, approved February 22nd, 1905, No. 434, in reference to the enforcement of vaccination, the following rules and regulations are herewith adopted and promulgated in reference to matters of vaccination and revaccination of all persons within the State who do not reside within the limits or jurisdiction of any incorporated city or town.

RULE I. That all persons within the State of South Carolina who do not reside within the limits or jurisdiction of an incorporated city or town shall be vaccinated, and revaccinated by the duly appointed agents of the said State Board of Health, except persons who may obtain a certificate of a reputable physician that vaccination would be dangerous to health, at the following periods: During the first, sixth and fifteenth years of the age of the persons; and that all persons who have never been vaccinated, or shall be exposed, or are likely to become exposed to small pox, shall be vaccinated forthwith: *Provided*, That the charge for each vaccination shall be ten cents except the indigent persons, to whom the charge shall be nothing.

RULE II. No superintendent of any institution of learning and no school board or principal of any school in the State, not located within a city or town shall admit as a pupil any child or persons who cannot produce satisfactory evidence of having been vaccinated as often as required in Rule I above, and it is hereby made the duty of every parent, guardian or other persons charged with the care or responsibility for any child to see that such child, if not a resident of a city or town, is vaccinated as often as required by Rule I.

Section 6 of the Act above referred to provided: "Any officer or person who shall fail, neglect or refuse to comply with any provision of this Act applicable to such officer or person shall be guilty of a misdemeanor, and upon conviction thereof in a court of competent jurisdiction shall be fined in the sum of one hundred dollars, or to be imprisoned for thirty days."

The following form for ordinances is submitted for the consideration of the various municipalities to carry out the law therein referred to which is hereinafter printed. This is merely a suggestion as to the form and contents, and any other conforming to the Act will be satisfactory, observing, of course the charter rules governing the manner, time, formalities, etc., creating an ordinance or municipal law, and the periods of time for vaccination, which under Section 1 of the Act must be satisfactory to the State Board as set forth in the ordinances submitted:

Be it Ordained by the.....Council of .....in due session assembled the.....day of ....., That in pursuance of an Act of the General Assembly, No. 434, approved the 22nd day of February, A. D., 1905, entitled, "An Act authorizing the passage of ordinances by incorporated cities and towns, and the promulgation of rules and regulations by the State Board of Health, to enforce and compel the vaccination and revaccination of citizens and residents of the State of South Carolina; and prescribing the duties of certain officials and persons to that end, and providing certain penalties for failure, refusal or neglect, to comply with the provisions of same," and such other laws governing the matter.



SECTION 1. That all citizens and residents of the town (or city) of.....be vaccinated and revaccinated with fresh bovine virus under the direction of the health authorities of said town (or city) or of some competent physician appointed for that purpose, except such persons as may obtain a certificate of a reputable physician that vaccination would be dangerous to health.

SECTION 2. That such vaccination and revaccination shall be made within the first year, and during the sixth and fifteenth years of the age of such residents and citizens, and that all residents and citizens who have never been vaccinated, or shall be exposed, or are likely to become exposed to small pox, shall be vaccinated forthwith: *Provided*, that indigent and pauper persons shall be vaccinated and revaccinated at the expense of the city (or town.)

SECTION 3. That for neglect or refusal to obey the provisions of the ordinances herein, such person or persons shall be quarantined in such manner and under such conditions as the health authority of the town (or city) or some competent physician duly appointed may direct.

SECTION 4. No superintendent of any institution of learning, and no school board or principal of any school in this town (or city) shall admit as a pupil any child or person who cannot produce satisfactory evidence of having been vaccinated as required in section 2, and it is hereby made the duty of every parent, guardian or other person charged with the care of or responsibility for any child to see that such child is vaccinated as often as required by Section 2.

SECTION 5. That any officer or person who shall neglect or refuse to comply with the provisions of these ordinances shall upon conviction be fined a sum of one hundred dollars, or to be imprisoned for thirty days

The attention of municipal authorities is particularly called to Section 3 of the Act, and owing to the duties imposed upon the State Board by that Section, such authorities are earnestly requested to forward a copy of its ordinances to the Secretary of the State Board of Health. Your attention is also directed to Section 1, Act No. 450, (hereinafter printed) entitled: "An Act to prevent the spread of contagious diseases," making it mandatory that each incorporated village, town and city shall have and maintain a Board of Health, and Section 4, imposing a penalty for a neglect or refusal.

Upon application to the Secretary of the State Board of Health fresh bovine virus will be supplied to cities, towns and individuals without cost, provided that all unused points be returned to the Secretary.

For other information or instruction address the Secretary.

All of which done and adopted by order of the State Board of Health at Columbia, S. C., this 11th day of May, 1905.

T. GRANGE SIMONS, M. D.,  
Chairman, Charleston, S. C.

JAMES EVANS, M. D.,  
Secretary, Florence, S. C.  
May 12th, 1905.

## AGENTS OF STATE BOARD OF HEALTH TO ENFORCE COMPULSORY VAC- CINATION IN EACH COUNTY.

### 1st District.

Charleston.....Dr. H. W. DeSaussure Charleston  
Colleton.....Dr. J. T. Taylor.....Adam's Run  
Berkeley.....Dr. W. K. Fishburn.....Pinopolis  
Dorchester.....Dr. A. H. Hayden.....Summerville  
Clarendon.....Dr. L. C. Stukes.....Summerton

### 2nd District.

Aiken.....Dr. H. H. Wyman.....Aiken  
Barnwell.....Dr. E. L. Patterson.....Barnwell  
Beaufort.....Dr. H. M. Stuart.....Beaufort  
Hampton.....Dr. C. Aiken Rush.....Hampton  
Edgefield.....Dr. J. G. Edwards.....Edgefield  
Bamberg.....Dr. J. R. McCormick.....Ola  
Saluda.....Dr. J. T. Pitts.....Big Creek

### 3rd District.

Abbeville.....Dr. C. C. Gambrel.....Abbeville  
Anderson.....Dr. W. F. Ashmore.....Anderson  
Greenwood.....Dr. R. B. Epting.....Greenwood  
Newberry.....Dr. J. Gregg McMaster Newberry  
Oconee.....Dr. J. W. Bell.....Walhalla  
Pickens.....Dr. Jas. L. Bolt.....Pickens

### 4th District.

Union.....Dr. W. G. Going.....Union  
Spartanburg.....Dr. W. G. Sexton.....Spartanburg  
Laurens.....Dr. Ferguson.....Laurens  
Greenville.....Dr. G. L. Martin.....Greenville

### 5th District.

York.....Dr. J. E. Massey.....Rock Hill  
Chester.....Dr. A. M. Wylie.....Chester  
Fairfield.....Dr. R. B. Hanahan.....Winnsboro  
Lancaster.....Dr. R. C. Brown.....Lancaster  
Kershaw.....Dr. W. J. Burdell.....Langoff  
Cherokee.....Dr. R. F. McCown.....Cherokee Falls  
Chesterfield.....Dr. T. E. Lucas.....Chesterfield

### 6th District.

Marlboro.....Dr. W. J. Crossland.....Bennettsville  
Darlington.....Dr. A. J. Briggs.....Darlington  
Marion.....Dr. Z. G. Smith.....Marion  
Horry.....Dr. E. Norton.....Conway  
Georgetown.....Dr. W. E. Sparkman.....Georgetown  
Florence.....Dr. P. B. Bacot.....Florence  
Williamsburg.....Dr. Jos. F. Haselden.....Greeleyville

### 7th District.

Lexington.....Dr. Matthias Jones.....  
Sumter.....Dr. F. M. Dwight.....Wedgefield  
Lee.....Dr. J. W. Tarrant.....Magnolia  
Orangeburg.....Dr. Walter.....Orangeburg  
Richland.....None appointed.

## REDUCTION OF INFANT DEATH RATE.

*Modified and pasturized milk* has reduced the infant death rate in Liverpool, as appears from the statistics. In 1903 the general infant death rate was 159 to the 1,000 born, while among those fed on *modified and pasturized milk*, the infant death rate was 78 to the 1,000 born. Since the scheme was initiated in 1901 the lives of 650 children were saved, besides giving health and vigor to thousands who otherwise would probably be ill nourished and puny. The milk is furnished by the city at a price slightly above cost. The milk is intended solely for the use of those infants whose mothers are unable to suckle them, or who can only partially suckle them. This fact is stamped upon every card of instructions. The Liverpool health officer remarks:

"The problem of finding a complete substitute for the milk of a healthy mother has not been solved, and probably never will be solved. As the infant grows there may, no doubt, be variation in the quality of the mother's milk which specially adapts it to the infant's need, niceties in nature which can not be approached artificially. The use of artificial food is unavoidable under the existing social conditions; the nearest approach to the natural food is derived from cow's milk, which can be so altered as to closely imitate human milk in its composition, and it can also be made to resemble it in another important particular, viz., it can be sterilized, and given while so sterilized."

As administered in Liverpool, I believe that medical men indorse the scheme with practical unanimity. Without going into the elaborate statistics available, it can be said that the results in Liverpool prove that the system has effected a great saving of infant life.

—*Bulletin Indiana State Board of Health.*

## CORRESPONDENCE.

CHESTER, S. C., June 7, 1905.

Editor *Journal S. C. Med. Asso.*,  
No. 4 Vanderhorst St.,  
Charleston, S. C.

DEAR SIR:

Pardon me for not answering your communication of a few days ago, earlier, but the delay has been unavoidable.

I herewith enclose you on a separate sheet a list of members with their post office addresses of The Chester County Medical Society. The following are the officers of the society:

President, Dr. J. P. Young, Richburg, S. C.

Vice-Pres., Dr. H. E. McConnell, Chester, S. C.

Secy. and Treas., Dr. W. B. Cox, Chester, S. C.

The physicians of the city of Chester have started a movement to establish a medical library. In addition to our county organization, we have another, composed of the physicians of the city. We meet monthly at the homes of the different physicians. We meet in regular rotation on the 2nd Friday evening of each month. After refreshments are served, the remaining hours of the evening are spent in a social way; we have no program for these meetings. They promote harmony and good feeling among the fraternity. Every physician in the city belongs to this organization, and this speaks a great deal—it shows perfect harmony and the best of feeling among the physicians of Chester. If such harmony and good feeling existed among the physicians of the entire State, what a grand State organization we might have.

I write you this as a matter of medical information, and you may use it as you think best.

With best wishes for *The Journal of the South Carolina Medical Association*, I am

Yours fraternally,

W. B. COX,

Secy. and Treas. Chester County Med. Society.



## COUNTY NEWS.

CHARLESTON.—The contract for building the new Roper Hospital has been awarded to Frank B. Gilbreath, of New York, and the work of construction was begun on May 29th.

Dr. E. L. Jager has begun the practice of his profession in the office of Dr. A. E. Baker.

COLUMBIA.—Dr. H. C. Dozier has given up the practice of medicine for the purpose of entering the ministry. He will enter the Theological Seminary at the University of the South, Sewanee, Tenn., at the opening of the next session.

DARLINGTON.—On May 16th a public meeting was held in behalf of the proposed Hospital. A number of addresses were delivered and much enthusiasm was shown.

HORRY.—A county society has been organized in Horry Co., with the following officers: Pres., J. S. Dusenbury, Conway, S. C.; Vice-Pres., J. W. Floyd, Julia, S. C.; Sec. and Treas., J. A. Norton, Conway, S. C.

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## MARRIAGES.

On April 19th, at Indianapolis, Ind., Dr. S. M. Dial, of Columbia, S. C., and Miss Mary L. Davis, of Indianapolis, Ind.

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## OBITUARIES.

### RR. J. C. W. KENNERLY.

Dr. J. C. W. Kennerly, of Mt. Wil-ling, Saluda Co., S. C., was born in Edge-

field Co., June 19th, 1830. After studying in the best schools of his section, Dr. Kennerly attended the medical college at Savannah, Ga., from which he was graduated in 1853. He was married in 1860 to Miss Myra Watson, who with three children still survives him.

Dr. Kennerly was a man of the highest personal and professional character, upright and fair in his dealings with his fellow men, and always observing strictly the ethics of his profession. He was devoted and loyal to the South Carolina medical association, whose meetings he always attended, save when higher duties detained him at home. We shall miss his genial presence.

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### DR. THOMAS PEARCE BAILEY.

Dr. Thomas Pearce Bailey was born in Charleston, S. C., May 21st, 1832. He entered the S. C. Medical College in 1851 and graduated from there in 1853. He was a contemporary of the late Prof. Francis T. Miles, who, among others of the class, became famous in the medical profession. Dr. Bailey was a true type of a S. C. gentleman, a devout Christian, and a noble physician. He served in the 10th S. C. regiment (Manigault's Brigade) during the war between the States, as surgeon.

After practicing in the Santee section for a while, he came to Georgetown, where he lived, spending his life, and doing much good among the poor.

He was president of the S. C. Medical Association in 1891 and always took great interest, not only in the Association, but in every endeavor which led to the upbuilding of the profession.


He was called to his reward on the 19th day of July, 1904.

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# The Journal

OF THE

## South Carolina Medical Association



PUBLISHED EVERY MONTH UNDER THE DIRECTION OF THE  
COMMITTEE ON PUBLICATION.

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### South Carolina Medical Association

Next Annual Meeting at Columbia, S. C., April 18th, 1906.

#### OFFICERS.

President. DAVIS FURMAN, M. D., Greenville

First Vice-President, S. W. PRYOR, M. D., Chester.

Second Vice-President, CROWN TORRENCE, M. D., Union.

Third Vice-President, D. B. FRONTIS, M. D., Ridge, Springs.

Secretary, T. P. WHALEY, M. D., Charleston.

Treasurer, C. P. AIMAR, M. D., Charleston.

#### COUNCILORS.

First District, E. F. PARKER, M. D., Charleston

Second District, T. G. CROFT, M. D., Aiken

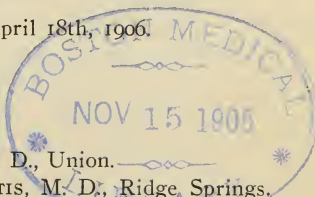
Third District, O. B. MAYER, M. D., Newberry

Seventh District, WALTER CHEYENE, Sumter.

Fourth District, J. W. JERVEY, M. D., Greenville

Fifth District, R. A. BRATTON, M. D., Yorkville

Sixth District, F. H. MCLEOD, M. D., Florence





THE STANDARD  
ANTISEPTIC

# LISTERINE



A non-toxic antiseptic of known and definite power, prepared in a form convenient for immediate use, of ready dilution, slightly, pleasant, and sufficiently powerful for all purposes of asepsis—these are advantages which Listerine embodies.

The success of Listerine is based upon merit, and the best advertisement of Listerine is—Listerine.

## LISTERINE DERMATIC SOAP,

An antiseptic detergent for use in the antiseptic treatment of diseases of the skin.

Listerine "Dermatic" Soap contains the essential antiseptic constituents of eucalyptus (1%), mentha, gaultheria and thyme (ea.  $\frac{1}{2}\%$ ), which enter into the composition of the well-known antiseptic preparation. Listerine, while the quality of excellence of the soap-stock employed as the vehicle for this medication, will be readily apparent when used upon the most delicate skin, and upon the scalp.

Listerine "Dermatic" Soap contains no animal fats, and none but the very best vegetable oils; after its manufacture, and before it is "milled" and pressed into cakes, a high percentage of an emollient oil is incorporated with the soap, and the smooth, elastic condition of the skin secured by using Listerine "Dermatic" Soap is largely due to the presence of this ingredient. Unusual care is exercised in the preparation of Listerine "Dermatic" Soap, and as the antiseptic constituents of Listerine are added to the soap after it has received its surplus of unsaponified emollient oil, they retain their peculiar antiseptic virtues and fragrance.



A sample of Listerine Dermatic Soap may be had upon application to the Manufacturers—

## LAMBERT PHARMACAL CO.

ST. LOUIS,  
U. S. A.

## The Carolina Sanitarium.

L. G. Corbett, M. D.

Greenville, S. C., July 1st, 1905.

Dear Doctor:

We are established for the treatment of drug and liquor addicts, and special nervous cases. We ask that you bear us in mind when seeking a place to send such patients and know that your confidence will be merited.

Rates reduced for treatment of regular practitioners.

Location and climate ideal.

Respectfully.

THE CAROLINA SANITARIUM.

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# THE JOURNAL

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## SOUTH CAROLINA MEDICAL ASSOCIATION.

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THE JOURNAL is published monthly under the auspices of the South Carolina Medical Association. Members who do not receive their copies will please notify the Managing Editor at once. Secretaries of county societies are requested to send reports of their meetings, and items of news that may be of interest to the profession. Original articles are solicited. Articles should be type-written; and illustrations sent with articles will be printed at the expense of the writer. Reprints will be furnished at the rate of 75c. a page for a hundred pages.

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### EDITORIAL COMMENT.

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#### STUDIES IN MALARIA IN ALGIERS.

In 1904 MM. Edmond and Etienne Sargent\* pursued studies in Algiers in the epidemiology and prophylaxis of Malaria, which confirm the observations of Koch, and throw an interesting light upon the sources from which anopheles derive their infection. According to these observers, the two important factors are, (1) the reservoir of the virus, and (2) the habitat of anopheles. Human beings harboring the malarial parasite constitute this reservoir of the virus, and in Algiers these were old European inhabitants, and especially native children. The percentage of infected children was determined by examinations of the blood and palpation of the spleen, and was termed the *endemic*

*index*. It is important to note that very often the infected individuals exhibited no marked manifestations. In a series of localities the proportion of infected children to the total number examined was from Jan. to Aug 1st, 46.4%; from Aug. 1st to Oct. 1st, 85.1%; and from Oct. 1st. to Nov. 30th, 80%. As a result of their observations they are able to declare that "in a given locality, the frequency of malaria diminishes if the reservoir of malarial virus diminishes, without any modification of the breeding places of anopheles." Several illustrative cases are cited. For example, "the village of Clichant, situated in the valley of the Mina, suffered very little from malaria during the summer of 1904, in proportion to neighboring localities situated in the same topographical conditions. Anopheles maculipennis are very numerous there as we were able to demonstrate in October. But the reservoir of the virus (the native population) is represented by a small number of individuals in comparison with the European population. There are at Clichant, according to the reports of M. Briquet, administrator of the commune, thirty natives inhabiting the European village, comprising about 290 persons. This proportion is very small in comparison with Algerian villages in general. On the contrary, 3 kilometres to the west, Morseli has been very much afflicted with fever this year." These observations possess a deep practical significance and point a moral to us in South Carolina. To effect the prophylaxis of malaria by destroying the breeding places of anopheles is an attractive proposition, but it is a means which cannot be applied in many instances because of the fact that these breeding places may be numerous, small and difficult to locate. If, however, we can prevent the infection of the anopheles

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\*Annales De L'Institute Pasteur, March, 1905.



by destroying the malarial organisms in the human bodies, malaria will disappear notwithstanding the presence of mosquitoes. This has been done with more or less success, by the administration of quinine in large doses for a long period of time. If the physicians in malarial districts would endeavor to educate their patients to this use of quinine a long step would be made in reaching a solution of one of the most important sanitary problems presented by local conditions. Drainage, isolation, protection by means of wire screens, and a liberal use of quinine during the summer and autumn months by those residing in unhealthy localities, whether showing symptoms of malaria or not, are the weapons which would enable us to greatly reduce if not entirely eradicate malaria.

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#### OSTEOPATHY.

The folly of osteopathy and the positive dangers to the public lurking in the system are illustrated by an advertising pamphlet distributed by an osteopath in Charleston. This man had the assurance to call upon several prominent physicians upon whom his modest deportment appeared to make a good impression, and who in consequence were at first a little disposed to look upon him with favor. In a short while an advertisement appeared in one of the daily papers stating that the "diseases treated include all forms of aches and pains, deformities, dislocations, stomach and bowel troubles, diseases of women, and many others." In the pamphlet the usual osteopathic claim is made that "the cause of disease, in general, is that disturbed mechanical relations of various parts of the body are potent causes of disease," and treatment is based upon the principle of "restoring harmony, which is

health, by readjusting through manipulations the deranged mechanism, whether that is found to be a slipped articulation, a contracted muscle or a tightened tendon." Taking up the specific affections, we are told that "in stomach troubles there are usually to be found some irregularities of the vertebrae, or ribs between the shoulder blades, which bring pressure on the nerves supplying the stomach wall." And in constipation "there invariably exists anatomical derangements of the spine—which must be removed before the bowels can be gotten into a normal condition." As we read on it grows worse and worse, e. g., in appendicitis, "by following up the well-established methods of osteopathic diagnosis the practitioner finds spinal derangements which interfere with the nutrition of the part, or shut off its proper nerve supply." And we are told further that "some of osteopathy's most signal victories have come through its successful handling of these cases." We are not disposed to doubt or to question the logic of the osteopath's conclusions—most likely we would reach the same goal if we, too, followed up "*the well-established methods of osteopathic diagnosis.*" If we could select our premises at will, without regard to truth, nothing would be easier than to prove by due process of logic that the moon is made of green cheese. Unfortunately the public are too ignorant to appreciate the fallacy of the osteopath's premises and the absurdity of his conclusions, and a few successful results of massage are heralded as evidence of the truth of the system.

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#### A SUGGESTION.

The note concerning the Kershaw County Medical Society, which appears in another column of this issue, suggests to

us that it would be an excellent idea for each county society to work up its local medical history, giving a narrative of the prominent men and what they have accomplished. In this way we would gather valuable material for a medical history of South Carolina. We need not comment upon the value and the interest sess.

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### APPENDICITIS.

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LE GRAND GUERRY, M. D., COLUMBIA, S. C.

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*Gentlemen of the South Carolina Medical Association:*

Appendicitis has been chosen as the subject of this paper because, of all the acute abdominal lesions known to the medical profession to-day, this is the most important. It is a fact that at the Massachusetts General Hospital in Boston during the year 1901 there were one thousand and two abdominal operations, and out of this number three hundred and thirty-seven were on the appendix alone. This condition is not confined to the Massachusetts General Hospital, gentlemen, but exists practically wherever surgery is done. This statement is made at the outset to impress you with the overshadowing importance of this disease, and with the imperative necessity of understanding its pathology and clinical history thoroughly enough to be early and accurate in diagnosis. It is about fifteen years since Fitz of Boston gave to the medical profession his classical treatise on appendicitis. It would not be wide of the mark very much to say that the birth of this disease was in Fitz' paper. Fitz taught us its pathology, he taught what the disease really was, and its scientific and rational treatment followed not only logically but of necessity. In spite of all the brilliant work that has been done and of all that has been written about this disease the last word has not yet been said. There are still questions concerning diagnosis, prognosis

and treatment that have yet to be settled. We shall first discuss the important clinical symptoms as bearing directly upon the question of diagnosis. We quote the following from Maurice Richardson:

"Symptoms are severe if pain continues unabated, with fever, right sided rigidity and tenderness, especially if there is vomiting and distention. The constitutional signs are less important than the local at this stage, for in some infections, even if they are general, the pulse and temperature may be but slightly affected. Indeed, constitutional symptoms greatly outweighing the local, should excite the most careful consideration when appendicitis is suspected, for the former may be merely the expression of an acute absorption from the gastro intestinal tract, the local signs being perhaps only a painful colic, affecting the right rather than the left side of the abdomen. On the other hand, pain that has made its way to the region of the appendix, that remains there, that is accompanied by extreme muscular rigidity and tenderness, even without fever, should excite apprehension and raise the question of intervention. With tumor and with fever these symptoms require operation, unless there is rapid and unmistakable amelioration; they demand it if there is constant vomiting and beginning distention, even if some of the symptoms show signs of improvement."

### PAIN.

According to the above quoted author, pain is the most urgent, the earliest, most important and most easily misinterpreted sign. In the beginning of an attack pain is usually felt over the entire abdomen, and at this time is especially referred to the umbilical regions. Within the first twenty-four hours it generally localizes itself to the definite area of the appendix, most usually under McBurney's point. If the infection does not become localized neither does the pain in the great majority of cases at least; in other words, the pain spreads *pari-passu* with the infection. In some cases we note a sudden subsidence of pain and then an almost equally



sudden reappearance; this means renewed infection, and the case should be most closely watched, as we may then have to deal with a condition of beginning general peritonitis. Given a patient with acute appendicitis, and, if after twenty-four hours the pain becomes more intense, operative aid is a necessity. It is useless to add that the pain is very sudden in onset.

#### TENDERNESS.

From onset to termination there is tenderness on pressure over the region of the appendix; we must remember here that the appendix is not always located in the same position, but commonly we find it under McBurney's point. Remembering the relation of the vermiform appendix to the caput-coli and remembering also that the same nerves which supply the appendix also supply the caecum and the ileo-caecal valve, we can readily understand that sudden pain is caused by the passage of gas over this inflamed area. On the other hand, dull and continuous pain indicates localized peritonitis.

#### NAUSEA AND VOMITING.

Ochsner's description of these symptoms is so admirable that we quote it entirely:—

"The localized congestion in the vicinity of the ileocaecal valve prevents the natural passage of gas and intestinal contents from the ileum into the caecum, and this, in turn, interferes with the physiological process of digestion of the food which has been taken into the stomach. We have, consequently, the same reason for return peristalsis that is present in any other form of mechanical intestinal obstruction. This condition gives rise, primarily, to a feeling of nausea; and, secondarily, if the condition is not changed, the undigested, decomposing food is forced back into the stomach by the persistent return peristalsis and there gives rise to vomiting, precisely as any other similarly nauseating substance would were it taken into the stomach through the mouth."

#### RIGIDITY.

This symptom is of utmost importance because by it we can early make a differential diagnosis between acute salpingitis, gastritis, biliary colic, etc. Rigidity is a symptom of onset rather than fully established appendicitis, for as the disease becomes fully shut off the tension diminishes and so does the rigidity. It means but one thing, involuntary protection of the underlying structures." "Rigidity with distinctly localized pain strongly suggests appendicitis, with fever it almost proves it and with tumor it fully establishes the diagnosis." This symptom alone will very surely be the index to the extent of the peritoneal invasion.

#### TEMPERATURE.

There is no more capricious symptom in appendicitis than this one of temperature, it may have a very grave significance or it may not, but, things being equal, temperature is a very important symptom. All of us have seen very slight lesions of the appendix with very high temperature, and on the other hand, very grave lesions with little or no temperature. Ochsner believed that more cases are lost because the physician in charge is not concerned about temperature, than from any other cause. A steady, continuous temperature or one that rises from 100° F. to 103° F. indicates either a local or a general infection, and according to Richardson, if these symptoms do not demand operation they demand very strong reasons for non-intervention. In the infections due to colon bacillus the temperature is low, in streptococcus the temperature very high.

#### PULSE.

The pulse is of prognostic rather than of diagnostic value. We believe it to be a great mistake to wait on the pulse to give us the indication for operation. It is very much like waiting on the condition of collapse before deciding to operate on a typhoid perforation, collapse is not a symptom of perforation, but it is rather the result of perforation. When the pulse is regular and in the neighborhood of 100

there is generally no immediate danger, although there may be great danger within a few hours. When high and of poor quality the pulse shows perhaps more than any other symptom the depth of the constitutional infection.

#### TUMOR.

When tumor occurs it adds a sign to the clinical aspect of the case that makes positive the diagnosis. Tumor is also of vast importance not only to the necessity of operation, but also for the site and extent of the incision.

#### TYMPANITES.

In the early hours of the attack tympanites is caused by the failure of gas to get by the inflamed ileo-caecal valve, in the later stages it is due to the decomposition of food.

#### LEUCOCYTOSIS.

When properly taken and at the proper time, we believe this to be one of the most, if not the most, valuable single signs, as well as, one of the most infallible. A Leucocytosis of 15,000, or over, in the early hours of an acute appendicitis, is most surely an indication for immediate operation; on the other hand, when the white cells are practically normal or only slightly increased the necessity for operation is not urgent. In a goodly number of cases we have operated solely on this sign, and have never had reason to regret it. We would impress the fact that the white cell count is of chief value in the early hours of the attack, more than any other sign we believe that it will point to the actual condition of the appendix.

The following is contained in a personal letter from one who stands at the head of the surgical profession in this country: "My feeling is this, if I have reason to suspect an appendicitis, no matter how mild the symptom may be, and yet find a leucocyte count of fifteen thousand or over, I operate at once without fail. If on the other hand, I am called to a case where the symptoms of appendicitis may be rather pronounced and yet with a low

leucocyte count, I am never in such a hurry to operate, and rarely under these circumstances find anything more than a catarrhal condition."

So much for the symptoms, gentlemen, I trust that they are sufficiently clear to be thoroughly understood. This paper does not deal with the question of when to operate because it is our belief that this point has to be decided by the surgical intuition of each individual operator, and cannot be determined by any fixed rule. We feel perfectly safe, however, in laying down this rule, that every case should be operated on as soon as the diagnosis is made, provided such diagnosis can be made within twenty-four hours. The reason for this is obvious, if it were possible to operate on all cases within twenty-four hours in nearly every instance we would operate before the infectious process has gotten beyond the appendix; in other words, we would be able to do clean work in an uncontaminated field. The cases are very few indeed in which the infection spreads beyond the appendix itself within twenty-four hours. So much for the early cases. As for the late ones, seen on the third, fourth, and fifth days of the attack, the clinical as well as the pathological condition is entirely different.

"After the first forty-eight hours the conditions found at operation differ materially from those of the earlier hours. Necrosis has been fully established, localization has become successful, or infection has become general. The appendix will be found embedded in recent adhesions; contiguous to it, surrounding it, or in some way connected with it will be found a foul-smelling liquid exudate teeming with bacteria. This exudate will vary in its localization between wide limits of peritoneum. It may be far to the right, behind the caecum; it may be high up, involving liver and kidney; it may fill the pelvis or cover the bladder; it may be buried among small intestines; it may be directly under the skin; it may appear even in the left lower quadrant of the abdomen.

Is it not fair to question a policy of universal intervention when cases are seen at



this most critical stage of the disease? To be perfectly fair, however, one must acknowledge that with increased experience the operative results in even the gravest forms of the disease are surely improving. Richardson puts the question in this way: "The essence of the whole question is to select those cases who without operation will recover and those who without operation will die." There is one class of cases we feel convinced that the mortality would be materially reduced by treating them after the method of Ochsner. Patients in approximately this condition, temperature 104° F., pulse 140, abdomen enormously distended, pinched features, delirium, and stercoraceous vomiting. These are the cases in which operation is attended with great mortality. I can do no better than to quote at this point a passage from Mynter's work on this subject:

"The third group is represented by twenty cases, Nos. 31 to 50 inclusive, all of which had gangrene with perforation and beginning or diffuse peritonitis. Five of these recovered while fifteen died, one of gangrene of the cecum, and one of pyelophlebitis suppurativa, after the peritonitis had disappeared, and thirteen of diffuse peritonitis. Two were operated on within twenty-four hours, three on the second day, three on the third day, five on the fourth day, two on the fifth day, four on the sixth day and one on the seventh day. The five who recovered were operated on in two cases on the first day, in two cases on the second day, and in one case on the third day. Of the fifteen patients who died one was operated during the second day, two on the third day, five on the fourth day, two on the fifth day, four on the sixth day, and one on the seventh day. Comments seem unnecessary. All died if operated on later than the third day."

The whole question of appendiceal surgery would be settled were it possible for us to know one thing, when is an inflamed appendix for the first time going to give rise to serious trouble? This question we do not know and there is no way at present to find out. Could we know

this we would always anticipate the danger by the aseptic removal of an aseptic appendix. We will close our paper by the following quotation because it sums up the situation better and more thoroughly than has ever been done by anyone else so far as we know at least, and it does give us in a general way an insight into the question of when to operate and when to advise operation.

"The indications for operation in appendicitis are present whenever the disease is strongly suspected in patients whose general and local conditions justify the operation. Some cases should be operated upon immediately, some require delay for a more favorable opportunity, some permit leisurely selection of a convenient time. The time for operation is the important consideration, chronic cases may be operated upon at any time, for they are all practically aseptic and permit immediate closure of the wound. Acute cases may or may not be operated upon at once, the question is too broad to be discussed at this time, it is a great mistake to remove an appendix as soon as the temperature has reached the normal line, for there is little to be gained over the operation in the acute stage, the infection is quite as virulent and therefore quite as dangerous, closure of the wound is prolific of disaster and drainage is necessary. Many a death has followed an operation at this time, when the wound has been tightly closed." The patient should be left until a month at least has elapsed after complete convalescence."

Such, gentlemen, is the feeble presentation of one of the most vital questions that engages the attention of the general surgeon. The paper may not have been helpful, for claim is made neither to novelty or originality but an earnest endeavor has been made to present the subject in the most advanced light. We certainly have reached the goal of an honest endeavor.

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#### DISCUSSION.

DR. C. B. EARLE: In company with the other members of this Association, I wish to thank Dr. Guerry for this able presentation of this subject.

He disclaims any originality in its presentation, but I think Dr. Guerry is at least original in one thing, that he has presented the principles of the disease, rather than a long list of cases which are of no interest except to the author of the paper. I am glad to hear one paper in which reports of uninteresting cases are left out.

In the main, I think everyone must agree with Dr. Guerry in his description of the symptoms, diagnosis and treatment of appendicitis. But in some few matters I think exception can be taken. I am sorry he did not lay more stress upon the symptom of pain in this disease. To me it is the most important of all the single symptoms we meet with in making a diagnosis of acute inflammation. The typical course, pain commencing at the umbilicus and gradually becoming localized with the appendix, will alone justify the diagnosis of appendicitis. But pain that possibly starts on the left side, as it almost always does in cases of appendicitis, where the appendix is located in the pelvis. A misleading symptom of pain was brought to my attention a few months ago, in which two of the most intelligent practitioners I know were attending a case in an adjoining county for three days. The man was suddenly taken sick, with pain on the left side; no tenderness, no history of rigidity of the right rectus muscle or of the right abdominal muscles that I could find out, but I saw him on the evening of the fourth day, and got a history of intense pain up to the day preceding, which had suddenly stopped, and with this cessation of pain there was an increase of pulse rate and a drop in temperature, and all the symptoms of shock—a typical case of rupture of the appendix. At the request of the father I operated on the boy, and found the appendix ruptured, general peritonitis, and the boy died two hours later.

As Dr. Murphy so well describes in his recent review of 2,000 cases of appendicitis, when symptoms in his cases have come on, first with pain about the center of the abdomen, gradually localized over the appendix, then nausea, then rise of temperature, his conclusions, I think, will voice the experience of most of us when he says, if the fever comes on with the pain, if the nausea precedes the pain, then he would doubt its being a case of acute appendicitis.

Another most important symptom, Dr. Guerry has laid stress on; the rigidity of the right abdominal muscles, in cases where the appendix is normally located, that is, in about 90 odd per cent. But in those cases in which it does not lie there, I don't think you will usually find the rigidity of the abdominal muscles, so that even that symptom is misleading.

In the matter of leucocytosis, my personal experience is very slight, but from others with whom I have spoken, and whose reports I have read, I think we are liable to lay too much stress upon that symptom. Pus has been found present in cases with leucocytosis below 15,000; other cases, with the leucocytosis exceeding 30,000, even 35,000, have proceeded and got normal convalescence without operative measures. So I think that instead of absolute proportion of leucocytes in the blood count, that we should pay more attention as to whether the leucocytosis is increasing, at a stand-still, or decreasing. If the leucocytosis increases in the first 24 hours, it calls for immediate operative measures. But if,

on the other hand, we find even 25,000, and a few hours later find it decreasing in amount to 20,000, or even 18,000, can safely leave that case to normal convalescence, especially if it occurs, as Dr. Guerry says, after 36 or 48 hours.

DR. T. P. WHALEY: I have listened with a great deal of pleasure to both the paper and the discussion, and there is little left for me to say, but there are some points in the paper for discussion still open I think.

Dr. Guerry said that pain indicated a severe infection—that pain was indicative of a severe case. I can recall in my own experience a case that came into my office on the night of the 4th of last July. A male youth, 26 years of age. He said he had been out rowing that day, and had been seized with a little pain in his side, and had vomited. He felt better then but his father sent him to see me. He had no fever at all—temperature might have been slightly above normal. He had absolutely no rigidity over the right side; said he had absolutely no pain over the right side, and scarcely any tenderness on pressure, discoverable by examination. His pulse—the point that Dr. Guerry laid so little stress on—his pulse was 109. Taking the history of the case: pain in right side and the pulse even without the rigidity. I made a diagnosis of appendicitis, and asked would he like consultation. He said that he would, and I sent him to Dr. Baker. Dr. Baker agreed with me but thought we could put off the operation until morning. I told him I didn't like the boy's pulse, and thought he should be operated on that night. He agreed, and we operated that night, and found about an inch of the appendix gangrenous. I am satisfied the boy would have died if we had waited until morning. The operative indication in this case was the pulse. I know of two more cases in which the pulse was a guide to operation.

In regard to nausea, and vomiting. Dr. Murphy, as Dr. Earle says, lays special stress on pain, succeeded in a reasonable time by nausea and vomiting. Dr. Murphy says that in appendicitis you have a perfect rhythm of symptoms. I do not believe that. He maintains that the fever only appears 8 or 10 hours after the pain—he gives you a sequence of all symptoms—nausea, pain and vomiting, and then fever 8 or 10 hours afterwards. I was impressed by his article, and believe he is right in the main as to the sequence of symptoms, but I know there are others who think otherwise.

In regard to rigidity, I can mention a case in my own experience in which there was no rigidity, but in which the patient died later on from appendicitis with peritonitis following. The way we accounted for absence of rigidity in that case, was because the abdominal muscles were so infinitesimally thin, scarcely strong enough to produce rigidity.

In regard to temperature, I do not attach any importance to it in the early stages.

As to leucocytosis: I have made very few leucocytosis counts in appendicitis, but I believe it is a very important element in the diagnosis. I would rather operate on a doubtful case in the early stages and remove a normal appendix, or ring on the right side than to wait and remove a gangrenous appendix later.

Some men seem to think the diagnosis easy? I



think it is very difficult, when we consider the other structures in the right iliaefossa which can give trouble, and other diseases for which operations for appendicitis have been performed. Even pneumonia has been operated on, because of pains in the right iliaefossa. Hysterical women have been operated on for appendicitis—neuralgia and abscesses have also led to operation for appendicitis.

I believe that Dr. Forest Willard's remarks are still applicable to-day as to diagnosis. In 1899 he said, in Philadelphia, that an individual could have pain in the right iliac fossa without having appendicitis, and that women could have an abscess in the pelvis without its being due to pyosalpinx.

DR. S. C. BAKER: I have enjoyed the paper, and also the discussion. As to these leucocytes, as one of the gentlemen said here in discussing a paper, I think that is a question that applies more particularly to the city physician than to the country doctor. Appendicitis is not limited to the city, however, and the diagnosis and decision as to operation frequently has to be made in a very short time in the country, where this count cannot be resorted to, and therefore, I say, its utility will probably be mainly confined to the larger cities and to the larger hospitals, in those cities. There is hardly any symptom, in my experience, that we can tie to as the principal symptom in making a diagnosis. I think with me it is the symptoms complex. We can hardly tell which of the symptoms we lay the most stress upon in deciding as to whether or not there is a case of appendicitis present. Sometimes it is one thing, sometimes it is another; sometimes the appearance of the patient. We cannot tell what it is many instances that decides us.

There is one form of appendicitis which Dr. Guerry did not mention, and which I have had occasion to deal with, and that is what I call cerebral appendicitis. That was a case in which all the symptoms were present; rigidity, and some nausea and pain, and everything else that should be there—a little bit of rising temperature. I did not have the blood count made. I operated on that lady, and found she had an atrophied appendix—it was about an inch long—and I was very much chagrined at the outcome of my diagnosis. There are a number of cases of this hysterical appendicitis met with. I found she had a floating kidney, and about a month after the operation for appendicitis I anchored it, and she has not had any symptoms of appendicitis since.

DR. A. H. HAYDEN: This subject interests not only surgeons, but physicians. I am a non-connoisseur. But I think that the consideration of leucocytosis, so far as appendicitis is concerned, might be eliminated. There are a great many nervous conditions which will give us the same blood count that we may find in proven appendicitis, whatever the blood count may be. I believe, to refer particularly to Dr. Knowlton's remarks, that the pulse is a better indication than the temperature. I think that in cases of appendicitis, before operation, we may be guided in our opinions as we are in cases of surgery. After laparotomy, for instance, we may have sudden rises of temperature, as high often as 102 to 104, even with a pulse ranging, say, from 80 to 90. I

have yet to see the surgeon who feels apprehensive about his patient so long as the pulse remains all right. There are many conditions which may cause a rise of temperature for some hours, even 24 hours, but so long as the pulse remains normal, or near normal, I believe that is the best index which we may consult in forming our ideas relative to prognosis.

So far as the pain is concerned, I have heard no one, in discussing this paper, refer to the peculiarities of the pain of appendicitis. I have never expressed this opinion before, and never heard it expressed, but having been unfortunate enough to have a good many cases, a number of which have gone to operation, I have made this rule for my own personal guidance, relative to colics, or abdominal pains. The pain of appendicitis, I think, so far as my personal observation is concerned, is very, very characteristic. We might have a so-called colic. The question immediately arises, what is the cause? First of all, in appendicitis, or colic of any kind, we look to the etiology of the trouble. We oftentimes—and I believe, 99 times out of 100—when called to a patient who has a colic, are unable to state the cause just at a glance. We follow the routine practice, or what should be the routine practice where colic exists; we empty the stomach, if necessary by an emetic, and empty the entire elementary canal, by enema, purgatives, or what not. When we are satisfied they are empty, and we have the colic remaining, I believe that beyond question of peradventure it is appendicitis. I believe, furthermore, that pain in appendicitis is a very distinctive pain—it is an intermittent pain—and if any of you practitioners here present will watch your next case closely, and take your watch in hand between the paroxysms, I believe that the pain will come with almost the regularity that the pyrexia does in a typical case of intermittent fever.

DR. A. B. KNOWLTON: I have enjoyed Dr. Guerry's paper, dealing, as one of the gentlemen who preceded me said, not with tiresome cases, but with classical symptoms of practical interest to every man in this hall.

But with one or two points permit me to take exception. One is the leucocyte count. No doubt, as he says, with regard to appendicitis itself, the last has not been said as to the leucocyte count, and I don't believe the time has arrived when we can go even to the extent of the surgeon whom the doctor quoted as being most prominent on that point. For instance, when the leucocyte count reaches 15,000 you should operate. But in making that statement, it implies that if there is an absence of 15,000, or say 12,000 instead of 15,000, that you may very safely wait. Right there I wish to branch off. I do not think we can afford to wait. Only in the last few days I had the pleasure of Dr. Guerry's consultation, wherein he gave that advice, and the leucocytosis was 12,000. It seemed to me that the patient's condition was perfectly ideal. I could not imagine a man with appendicitis whose condition was more ideal. His pulse was 104, and his temperature then, in the 36th hour of the disease, was 99½. He had gone 34 hours without any constitutional symptoms, and at the end of 36 hours the count was only 12,000. I operated on the young man, and found an extremely adherent appendix, and there was no pus. There was a little fluid—I don't know what it

consisted of, but a little darkish fluid in the lower end of the appendix. There was an odor to this fluid on opening the appendix, and I believe that man would have died from perforation very soon if not operated on.

Three reasons seem to me practical, why we should have trouble in the ascending colon. One is: We all know that when water is passing through a tube, that when it comes to a dilated portion of the tube it travels of necessity at a much lower rate of speed. So with fecal matter, mixing with a large portion of fluid, it enters the cecum and the ascending colon, it must of necessity travel at a lower rate of speed. That induces fermentation, of course. Another reason is this: That one of the chief functions of the colon is the absorption of fluid that passes through down to the cecum. That absorption additionally entails a slower rate of speed of this matter through the bowel. That means again a fermentation, and gases a trouble, leading, I think, additionally, to affection of the appendix. When the fecal matter gets to the cecum it has an up-grade course to pursue for 12 to 18 inches. Thus if a man has been walking about, it is opposition to the force of gravity. It seems to me those are three very good reasons why we should expect to have trouble at that point more than anywhere else.

I believe that the pulse, taken all in all, is the most reliable symptom we have as a guide to operation.

Take any one symptom to the exclusion of all the others I believe that unless the leucocyte count comes more to the front than it has at the present time, I believe the pulse is established as the criterion symptom.

One symptom is this: In matters of indigestion. If there is one thing we should expect with regard to diseases whether medical or surgical, of the entire intestinal tract, it is indigestion, which we expect when it is out of order—little gas, and nausea, and pain, and all that goes to make up the entire field of indigestion. I do not think appendicitis as a rule commences abruptly. I do not believe in a well man to-day and a sick man to-morrow with acute appendicitis. If you make a close investigation you will find that for months and even years there has been indigestion. And I believe you will find this, that it is absolutely incurable by the ordinary medicinal agents we have, in the way of digestants and dietary remedies. Indigestion is curable only temporarily by emptying the intestinal canal, simply because you have removed the *casus belli*.

We have had in our little infirmary about 60 cases of appendicitis, with one death. That was a student from the college, a young lady. The leucocyte count was a little over 10,000, and notwithstanding that she had a temperature of 102½, she had a pulse of 140, and she had considerable pus, and in our manipulations we unfortunately ruptured the pus sac and the patient died. That was in spite of the low leucocyte count. And I can cite 8 or 9 cases, for which I can vouch by the authority of the bacteriologists in Columbia, where the leucocyte count was below 15,000, and these cases had either perforations, gangrene, or little sloughs. In other words, the leucocyte count would have let these patients go until they would have died.

DR. H. A. ROYSTER, OF RALIEGH, N. C.: I always hesitate to say anything more about appendicitis. In the first place, I find that my mind changes so often that what I have said before I would like to retract, because every operation I do I find out something about the appendix and its diseases that I did not know before. And especially on this occasion I feel unprepared to engage in any formal discussion. But this subject has been so well presented by Dr. Guerry, and the discussion has been so interesting, and along such proper lines, that I could hardly hold my peace any longer, even at the risk of saying something else that I would like to retract next year.

Dr. Guerry did not attempt to cover the ground. His sole idea was to bring out the questions of diagnosis and symptomatology, which he did in very clear fashion; and, after all, that is the most important thing for us. Pathology is the basis of all medicine and all surgery. A pathologist is neither a practitioner, or a surgeon, but he can be both. The pathology of appendicitis was expressed by Dr. Murphy years ago in this fashion:

During the first 24 hours it is limited to the appendix; the second 24 hours extending beyond the appendix; the third 24 hours invading the surrounding tissues. What can be more clear, then, than such a summary, and what greater insight into the question of when to operate could be given than that?

The pathology of the appendix is simply a study of bacteriology, plus the anatomy of the appendix and the peritoneum.

I have been very much interested lately in reading an article by Stallenburg, of Red Lands, California, upon the subject of cessation of pain.

Etiologically, all will agree that it is due to interference with circulation between the base of the appendix and its top, either in the mesentery, which carries the blood vessels, or in the appendix itself. If one appreciates this, he is prepared to understand the most important symptom in appendicitis, namely, pain. But pain, while an important symptom, is not characteristic. If we expect anything to be characteristic in medicine, we will be unsuccessful. An important point to bring out in connection with the pain, and especially so, I might say, with great respect to the general practitioner is this: If your patient has suffered pain and has a sudden cessation, he is not better, but worse. Time after time cases have been sent to me by most reputable physicians, who say, "I had this case 36 hours, with intense pain; gave morphine, and the patient got better—fever was lower, and considered the patient better." There can be no greater mistake. Sudden cessation of pain means rupture of the appendix—means a break in the wall. It does not mean anything but a condition in which the last state of that man is worse than the first. That is the particular thing to call attention to in the subject of pain.

Dr. Ochsner, of Chicago, thrust upon the profession some years ago, a treatment, the reason for which has been outlined by Dr. Guerry, and I would like to make a few brief statements in regard to that. It is this: You get these 11th hour patients too early for the late operation, and too late for the early operation. You have two courses; you can operate immediately, or



wait. In waiting, you run a risk, unless you do two things he prescribes; wash out the stomach, and give an ounce of panapeptoine and 3 ounces salt solution by the rectum every four hours, preceded by one large copious soap-suds enema; then give the patient, by the mouth, just enough water to keep his thirst from being excessive. If you do that you will find the temperature slow down, a normal pulse—will go to 160 and stay there—and when you open that belly in a week you will find the pus easier to get at, and conditions better in which to remove the appendix. In one out of every ten cases he has found that the omentum had wrapped around the head of the appendix.

I have treated over a dozen cases by that method, and have lost one—a serious case, put off because the operation offered no hope. It looks unscientific, appears to be unsurgical, but has proved valuable.

I saw 40 cases under this treatment at Dr. Ochsner's, and saw them operated on afterwards, and observed the pathological conditions present. It would take too long to go into the theory here, but that is the principle, and I must say I have become at least partially converted. Next year I may change my mind, but at present I feel I can accept this treatment with perfect equanimity.

We all lose cases of appendicitis; lose cases that look as if they were going to get well, and save cases that look as if they were going to die. Remember another thing: systematic invasion has as much to do with it as local conditions. Remember also that the man who does not have any deaths is either a liar, or does not operate much.

DR. GUERRY: I certainly feel very grateful to the Association. It will always be a pleasant remembrance to me to think that my paper elicited such discussion. I believe the discussion has been undoubtedly the best part of the whole paper.

I think the lesson we want to learn about the appendix is this—that everybody wants to learn—that the general practitioner wants to learn, and, generally speaking, testify to—that there is a time that practically every case of appendicitis can be cured. The question resolves itself to as nearly as possible find that time. If we could operate on every case within 24 hours, we could not save them all, but would come very near it. The thing we want to be able to do is to make early and accurate diagnosis, and early operation. It is the delay, and it is the condition that might be brought about by delay, that causes fatality in the majority of fatal cases, and not the operation *per se*.

I think the paper was a little misunderstood in this respect; I did not mean to convey the impression that any one sign was all important. I think that is a great mistake to make, and a mistake so many men make who will study this subject and try to do work along this line and rely upon any one sign or symptom as most important—there is not any. At one time one symptom may be the governing influence in determining operation, and at another time, another.

I rather feared the leucocyte count would be the subject of contention. As to Dr. Knowlton's remarks, I think both his cases very ably bear out the principle we tried to develop, and to place the responsibility on the appendix. In the second

instance he mentioned, the leucocyte count of 10,000, that was a localized abscess, with shut off walls. The leucocyte count under those conditions is a different proposition from the count in the early stages of appendicitis. Leucocytosis, in a late case, means pus—it has no relation to the advisability of operation. The chief value of the leucocyte count is in the beginning of an acute case of appendicitis. The case he cited, and in which I had the honor of conferring with him, bears out the idea. There was a case, within 24 hours, and by his own testimony it was an appendix that had been the seat of previous inflammatory pus, imbedded in adhesions, and that there was no rupture in that appendix. Of course, you would have leucocyte count of 12,000. It is not unusual to find in those cases a collection of blood and debris—if you didn't have an inflammatory condition there you would not have any leucocytosis.

One other point, to develop a little further an idea that Dr. Royster developed, about Dr. Ochsner's treatment, which I believe bids fair to revolutionize the surgery of these late spreading peritonitis cases. He bases that treatment on the belief that the chief factor in the dissemination of a peritoneal infection is a peristaltic movement of the bowels; that it is the effect of the evil administration of drugs, such as cathartics, which is the most misunderstood and misapplied agency in all cases of that sort. If you could find some way, in these cases of starting peritonitis to limit the movement of the bowel you would convert an acute case into an interval case, and by the means of *gastric lavage* you empty the stomach. While that wash is going on there is a great deal of regurgitation of foul putrid material.

You empty the canal of the fecal and decomposing substances which are advancing the case and causing peristaltic movement of the bowels.

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## PEDIATRICS PAST, PRESENT AND FUTURE.

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E. A. HINES, M. D., SENECA, S. C.

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A careful examination of the transactions of this honorable body for the decade of my membership reveals the startling fact, that only five or six papers have been presented upon a pediatric subject. The majority of these by specialists in other branches of medicine. It would appear, therefore, that the trite observation, "That pediatrics is the specialty of the general practitioner," is no longer applicable, but that it is the specialty of the specialist. I fear from this ratio that less than a dozen papers have been offered by general practitioners in more than half a century.

My title is indeed comprehensive, but as I have shown, your patience has not been over burdened in recent years from this standpoint, and I promise to be as brief as possible. At the outset I wish to borrow this dictum, viz., (1) that "modern pediatrics exhibits a scientific structure, including all disturbances of the life processes, arranged according to scientific principles, and in its completeness not reached by any other specialty in medicine." Glancing backward over the greater part of the period of this Association's existence and within which time pediatric science has come into the perfection alluded to I desire to present this picture. Dr. J. J. Black, an ex-interne of the Philadelphia Hospital, the largest institution and in the greatest medical centre at the time in America, says: "Great advances have been made in the general treatment and nourishment of infants in the last forty years. When I was a resident of the Philadelphia Hospital, Blockly, I had the opportunity of seeing something of the practical workings of the day in a foundling hospital, but before I had time to more than get a knowledge of the horrors of the system, much less attempt to apply remedies, my term had expired. At that day most of the foundlings of Philadelphia came to this hospital, and there were quite a number of these poor little waifs. In winter or in summer they nearly all died—starved to death as it were—from too much and ill-advised feeding, paradoxical as that may appear. Indeed, if one of them lived beyond infancy it was a curiosity. One or two in several years did so survive, and one named after President Lincoln was always looked upon with curiosity as a survivor of the holocaust of infants at Blockly. There was no system in caring for these bereft babies. A good, well meaning woman was at the head of it and the doctors looked in if any body was ill, or if they took sufficient interest to go oftener. Pauper inmates from among the women were the nurses. Imagine such a thing as asepsis, the use of antiseptics or any attention to detail with such a gang! The baby food was milk, generally diluted with water,

cold or hot, as best suited the convenience of the attendant. There was no special care of the milk, no special care of the bottles, and the same might serve for half a dozen children and, as a rule, were fitted with, as I remember, the long hose nipples, an abomination, an invention of the devil. The babies did not remain long, and the end was a death certificate of "Inanition" and a grave in "Potter's Field." With this picture in my mind I visited recently the great University of Pennsylvania, of which this institution is a part, and behold the marvelous transformation! In the maternity wards of the University hospital the babe of a day or a week was in charge of that beneficent angel the American-born trained nurse. The babe was taken from the breast with impunity when necessary and nourished for any length of time with predigested, sterilized modified cow's milk, and with all the rigid precautions of modern asepsis. A special children's hospital, with a country branch for convalescents, complete an ideal equipment. I show you here the record sheet which represents the interest taken in another institution whose modest laboratory through Duvall and Bassett proclaimed to the world the discovery of the Shiga bacillus in the stools of summer diarrhoea, The Thomas Wilson Sanitarium for Sick Children near Baltimore. Twenty-five years ago the American Medical Association created a section on Pediatrics, and the great work it has done has grown from year to year. Two years ago at the New Orleans meeting there was scarcely standing room in the hall provided by the committee. A similar interest was manifested a year ago at Atlantic City when the program contained the names of physicians, surgeons and specialists of international fame. Yet this is but the reflection of the awakening interest everywhere. You say that fame and fortune comes easiest to-day by way of surgery of the appendix, the gall bladder, the pancreas, the kidney and the female pelvis, but I deny that this should be the end of all effort. This continent has never been stirred by any scientist, save when Koch announced his cure for



tuberculosis, as when Prof. Lorenz visited us three years ago and demonstrated bloodless surgery as applicable to pediatrics. Those of us who witnessed his work and studied his results two years later, feel that the interest was well founded. A year ago Prof. Hoffa of Berlin, a pupil of Lorenz, was accorded similar honors, and with scarcely less interest, as he taught us the value of both the bloodless and open methods, with reference to congenital hip dislocation. There never was a time when general surgery offered wider opportunities. The surgical specialist has swung the pendulum to its extreme limit as applied to certain regions of the human body. I would call your attention therefore as general practitioners of medicine and surgery to the possibilities of success in pediatric surgery. There is no reason why the general practitioner, who, has the aptitude and training should not perform many of the operations which, in the large centers, are divided among so many specialists. Particularly is this true among those practitioners remote from these large cities. A Gross, an Agnew and a Pancoast demonstrated these possibilities in the past, and many homes would be brightened, if we should rise to our opportunity, by the correction of many hideous deformities, doing the simpler operations of the eye and ear, nose and throat. Bacteriology has given to pediatrics its greatest triumphs, antitoxin, purer milk, the milk laboratories, and the early diagnosis and treatment of ophthalmia neonatorum. Pediatrics has in return stimulated the entire world to further research, with some success, in the wonderful domain of Serum Therapy. You will admit that our weightiest problems and heaviest mortality in pediatrics occur in the summer months. With this idea I determined to study for the sake of truth and comparison child life where these conditions prevail perennially—the tropics. So far as I am aware this information has not been published hitherto in this country. Rev. C. R. Womeldorf, missionary to Brazil, a careful, scientific observer, writes me from Para—only a few miles south of the

equator: "As to infant feeding, cow's milk is of a poor quality and limited in quantity. The American physician here uses unsweetened condensed milk made in Switzerland or France, also sterilized milk from Europe. The Brazilians use a kind of mush or gruel made from mandioca meal. They begin giving this from the 2nd, day and in cases of diarrhoea, when they have not used this, they begin at once. They usually nurse and give this together, thinking mothers milk is not sufficient. It is interesting to note at the same time sad, the distended stomachs of the children here. You often see them leaning backward a little as they stand or walk because of the full stomach. Then when they are a year old they eat the dry mandioca meal, which swells in the stomach, stretching still more this organ. This mandioca meal is the staple food for the poor, even of the city and, more especially of the interior, where other foods are not to be had. It may be truly said as to child life here it must be a survival of the fittest, the weaker must succumb and pass from the scene. A total of 16,346 deaths for a five year period shows 4,931 children under 5 years of age. Causes, Congestive convulsions, 387; Tetanus, 310; Lack of Vitality, 201; Atresia, 125; Congenital Weakness, 54; Teething, 46. Many causes in the general statistics belong to children as well. I am pretty sure there is less artificial feeding here than in the U. S. without mothers' milk. It is used but with mother's milk. Children grow up until 5 to 8 or more years nude. You would often think they had had smallpox or measles from the marks of the mosquito bite."

The Rev. Phillips Verner, missionary to Africa, and member of the American Society for the Advancement of Science, and who has made close observations in the Congo Free State at a point just north of the equator, writes me: "Infant mortality is very high. Children are fed on soft cassava pudding before being weaned. The wet nurse is used, but it is common for the motherless infant to be sold. Cholera Infantum is frequent. Infants also die largely of Malarious fevers. Ver-

mes are common. The knowledge of how to relieve children's diseases even less developed than primitive medical practice on adults. Over-feeding is a frequent source of trouble. One admirable fact is frequent, the forbearance and self-control of parents during pregnancy and nursing. Polygamy has something to do with this, but I have known cases where this was true under ordinary conditions. As a matter of fact, contrary to much current thought, tropical peoples are less sexually passionate than the northern peoples. This is also the opinion of Dr. Mason of the Smithsonian Institution."

The mandioca and cassava foods aluded to are similar to our arrowroot.

America to-day is a leading nation in Pediatrics, however blindly we may follow others in all the other departments of medicine. Jacobi, Holt, Rotch, Sayre, O' Dwyer and others have made us known throughout the world. Now what have we done in South Carolina to offset our record pointed out at the beginning of this paper? Very little I fear. What steps have we taken for a purer milk supply. Bulletin No. 46 of the U. S. Bureau of Animal Industry reporting on the milk supply of 200 cities and towns tells the story in a short paragraph at the bottom of a single page. No efficient State law. No special city appropriation and special inspector, no milk laboratory. The already burdened boards of health attending to these matters along with other duties. Measures taken for the purpose of obtaining wholesome milk are not quite new. Regulations were given in Venice 1599 for the sale of milk. Milk and its products of diseased animals were forbidden. (2) The Paris municipality of 1792 enjoined the farmers to give their cows healthy food. Coloring and dilution of milk were strictly forbidden, and in 1792 they knew in France how to punish transgressors. It is time for us to act in this matter. Other Southern States are taking such steps. It remains now for me to point out briefly some of the signs of the times as touching the future. Sanatoria and private and public hospitals are being built rapidly in almost every town

and village and I plead for the child in these institutions. Small communities especially are panic stricken when the serious contagious diseases are announced. Trained assistance in these institutions would save many lives. Knoph of New York says: "It must be evident to every physican and sanitarian that multiple sanatoria for the treatment and care of tuberculous children is one of the most important factors in the fight against consumption. It was my privilege to serve for some time as assistant to such an institution in France. There, in the celebrated institution at Berk-sur-Mer, belonging to the city of Paris, we received weekly from ten to twenty-five little ones who had been operated on. The change which was wrought in the faces of these children after a few weeks sojourn at the seaside was something hard to believe. These pale-faced, underfed children, coming mainly from the homes of the poor of Paris, became rosy-cheeked and healthy looking youngsters in the ozone-laden atmosphere of the sea coast. A similar institution has been established at Seabreeze, near New York, and I trust will find numerous imitators among the philanthropists and municipalities of our country."

Fifteen years ago the late Prof De-Saussure and Prof. Lane Mullally of Charleston, established fresh air excursions at stated intervals for the poor children of the city of Charleston, which were supported by the contributions of the citizens. This beneficence has been kept up and another provision added for a limited number of sick children and their mothers on Sullivan's Island. The one remedy for a seeming lethargy in pediatrics lies with the medical schools. Pediatrics *demands* a full professorship everywhere, with the best of clinical equipment for practical instruction in special wards or special hospitals, and thus no longer to be a foundling on the door step of internal medicine, diseases of women and obstetrics. This may never be otherwise in actual practice but should be in teaching. Prof. Osler, in his now famous valedictory address at Johns Hop-



kins University, said: "I desire no other epitaph than the statement that I taught medicine in the wards, as I regard this as by far the most useful and important work I have been called on to do." A similar aspiration should be applied to pediatrics. The new hospital in Charleston will embody these advances with reference to special wards.

In addition to the names of the gentlemen already referred to I am indebted to Prof. Lane Mullally of Charleston and Dr. M. P. Ravenel of the University of Penn. for valuable suggestions.

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### ACUTE LOBAR PNEUMONIA.\*

JULIAN H. ALLEN, M. D.,

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Acute Lobar Pneumonia, one among the most fatal of all acute diseases to which human flesh is heir, is an acute infectious inflammation of the parenchyma of the lung, manifesting itself as a general toxoemia, with local disturbance in the lung, and passing through the recognized stages of congestion, hepatization, and resolution or disintegration. It is produced by the inhalation of the micrococcus lanceolatus, causing grave constitutional disturbances, as rigors, high temperature, and a great lowering of the vital power.

In reviewing the clinical course of a favorable case of pneumonia, we see it presented as follows: The initial chill; high temperature; increased frequency of respiration; pulse a little more frequent than normal, with full volume; high tension and normal rhythm; the tongue is coated, there is a loss of appetite, headache, more or less pronounced nervous

symptoms, a cough, rusty sputum, dry, hot skin, flushed face, and other symptoms with which we are all familiar.

These symptoms persist for a period of five to ten days, the most important change being in the frequency of respiration, loss of tension, and change of rhythm in pulse. At the end of this period there occurs a copious perspiration, the temperature falls to or below normal, the respiration becomes less frequent, pulse improves in rhythm, and convalescence is established. On the other hand, if the disease progresses unfavorably and passes into the stage of purulent infiltration, we notice quite a different state of affairs. The pulse becomes more frequent and feeble, expectorations more abundant and purulent, respiration is hurried, cyanosis marked, the vitality fails, and death closes the scene, produced either from intense toxoemia or from interference with oxygenation by involvement of too great an amount of lung area or from some complication.

Pneumonia is a disease which spares no age or sex; the young being as frequently affected as the aged. Males are more frequently affected than females.

Persons who for some time have been debilitated or suffering from chronic nephritis or diabetes are especially prone to the disease; also persons having had a previous attack of pneumonia, instead of being rendered to some extent immune, are, on the other hand, more liable to another attack. Alcoholism seems an important predisposing factor that is worthy of consideration. Climate exerts very little influence, since the disease appears equally in hot or cold countries. In fact, it is an almost universally distributed affection, appearing in every country on the globe. Some noticeable effect is produced by season, since the great majority of cases appear during the winter and spring months, say, from January to April.

The specific cause of pneumonia, as has already been stated, is the direct inhalation of the pneumococcus, which at first produces a local inflammation in the lung substance. Later on the toxins become diffused throughout the body, producing

\* Read before the Spartanburg Co. Medical Society, May 5, 1905.

all the grave constitutional disturbances noted in the course of the disease.

In the first stage of the disease we have diminished expansion of the affected lung. On percussion we get a note that is normal or high-pitched, and very frequently tympanitic in character. The respiratory sounds are greatly diminished. In the beginning of the second stage we hear the crepitant rale at the end of inspiration, and bronchial breathing is very pronounced over the solidified lung. On percussion we get a dull, flat note, which becomes more marked as the stage advances. In the stage of resolution we notice the movements of expansion gradually return, and the bronchial breathing is replaced by normal breath sounds. The dull percussion note does not clear up immediately, as a rule, but may persist for some time after convalescence. The symptoms during this stage denote progressive improvement.

In considering the prognosis of pneumonia, we must take into consideration the amount of lung tissue involved, the intensity of temperature, the diseases with which it may be complicated and the constitution and previous condition of the patient, all of which have a very important bearing in the course of the disease.

The pathological conditions with which pneumonia is most frequently complicated, are pleuritis, bronchitis and empyema, occurring in the order named.

In the treatment of pneumonia, we should consider the prophylactic as well as the general or active treatment. When we recognize the fact that persons suffering from chronic diseased conditions and those who for a long time have been debilitated generally, and especially patients who have had previous attacks of pneumonia, are much more liable to the disease, such persons should be very cautious as regards exposure to colds, and should never come in close contact with a case of pneumonia. If the sputum is disinfected and destroyed, the danger of communication is very much reduced. It seems to me that fully as much caution should be observed in the destruction of the sputa in this disease as in tuberculosis,

since the diseases are alike transmitted through the medium of the dried sputa.

The pneumonic patient should at all times expectorate on cloths or handkerchiefs, which should be immediately burned. Everything used by the patient, as glasses, spoons, etc., should be thoroughly sterilized before being used again by healthy individuals.

A patient suffering from pneumonia should be placed in a well lighted and well ventilated apartment. The room should be kept at a temperature of 65° or 70° F. He should be kept as quiet as possible, not even being allowed to rise to take food or medicines, if possible to prevent it. He should be kept in bed at least eight or ten days after the occurrence of the crisis.

As regards the active treatment of pneumonia, there are a great many different methods, but they all have substantially the same end in view, that is to maintain the efficiency of the heart through this self-limited affection. The guiding of the heart's action is the question of greatest importance, and yet this is the feature for which we can formulate no satisfactory rule, since each case presents its own problem, which frequently taxes the judgment and skill of the painstaking physician to the utmost.

The prime therapeutic measure in a beginning pneumonia, is the opening up of the bowels, and keeping them more or less active throughout the course of the disease. For this purpose an initial dose of calomel should be administered, followed by a saline laxative. In the stage of engorgement, when we find a full bounding pulse and evidences of a vigorous heart, tr. of aconite or veratrum, in moderate doses, for twenty-four or thirty-six hours, prove very useful remedies. Their action, however, should be carefully watched, since they are agents that are capable of doing much harm. A temperature that exceeds 103° F. calls for some antipyretic measure; a cold alcohol sponge bath may be given or phenacetin or acetanilid, in two or three grain doses, will generally meet the requirements.

When pain is a prominent symptom, it



may be relieved by the application of an ice bag to the chest or by hot applications. However, when there is very severe pain, and local applications have no effect, hypodermics of sulph. codeine or sulph. morphine may be used. Opiates should, however be given very cautiously, since they interfere greatly with respiration, and a great accumulation of mucus in the bronchial tubes positively contra-indicates their use.

Expectorants are generally not indicated; they usually disorder the stomach and interfere with the proper assimilation of foods, stimulants and other medicines, although when there is a copious, tenacious bronchial secretion, the aromatic spirits or carbonate of ammonia may prove of great value.

The essential factor throughout the disease is to maintain the heart's action, and the administration of stimulants should not be delayed until failing circulation peremptorily calls for it. The stimulant should be selected to suit the case; thus, in one instance, strychnine may prove the best stimulant, because it also improves the vascular tone; in another digitalis is better, and yet in another caffeine or alcohol may prove the best remedy. In critical cases, the cardiac stimulant should invariably be given by the hypodermic method, as the absorption by the stomach at this time is slow and unreliable.

The delirium in pneumonia, the control of which sometimes becomes a serious problem, may be relieved by the application of ice bags to the head, especially if it is the outcome of high temperature, where this is of no avail, we get good effects from codiene, bromides or trional; sometimes nothing short of morphine or hyoscine will quiet the delirium.

In the way of topical applications to the chest wall, a great many things have been used, as ice packs, hot poultices, mustard plasters, paintings of iodine, antiphlogistine, etc., none of them perhaps having the slightest influence on the course of the disease. For my own part, I prefer the cotton batting or flannel jacket reinforced with oil silk, which is made to cover the entire chest.

The proper selection of a diet is a question of paramount importance. The food should be liquid. Milk constitutes the best food, and should be chief article of diet, but, for the sake of variety, such articles may be given as beef broth, chicken broth, egg albumen, orange juice, etc. The amount of the food, and the time between each feeding, should be invariably prescribed by the physician.

The mouth should be frequently cleansed with some mild antiseptic solution, as listerine, hydrogen peroxide or solution boracic acid.

Pneumonia is a self-limited disease, and one for which we have no specific, and it is doubtful if any known remedy shortens the duration of the disease. Our chief aim, therefore, in treatment is to stimulate and support our patient until the crisis is passed and convalescence established.

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#### FRACTURES OF EVERY LIMB:

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##### Amputation: Recovery.

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BY M. J. D. DANTZLER, ELLOREE, S. C.

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The paper has not been written with the intention of ventilating any special surgical skill in the treatment of the case, but for the purpose of showing to what extent a man may be whipped and lashed almost to pieces by machinery, running by force of steam, and yet recover with useful limbs and under the most unfavorable circumstances for successful treatment.

Mr. Charles L., of Elloree, S. C., aged about 22 years, was, on the ninth of March, 1905, caught by a band and dragged up by the hands to the main shaft of a steam saw mill until his arms were wrapped around the shaft, of course snapping the bones of both arms, and was whirled around and around, his lower extremities being lashed against a wall on one side and the over-heading above, which were only two feet and three feet respectively from the shaft.

When the revolutions of the shaft were

stopped he remained suspended from the shaft with both fractured arms wound around the shaft up to the front part of the chest, pitifully calling for help, where he hung while one or two persons who were present fled for assistance. An aged woman ran to the scene and with the help of two negroes, by having the motion of the shaft reversed, released his mangled body from the shaft, and then summoned medical aid. On my way I picked up Dr. Browning, and on our arrival we found a most shocking and pitiable sight, the patient incessantly and impatiently pleading for medical relief from his intense sufferings.

The middle portion of the right radius and ulna were bare of flesh and sticking up like two prongs from his elbow, the hand hanging by a narrow strip of skin and flesh. The left humerus was broken in two places between the shoulder and elbow; the left fore-arm was fractured between the lower and middle third; one of the bones had pierced the skin, but had been drawn back in releasing him from the shaft. The right fibula and tibia were fractured just below the knee joint. The left femur was fractured about its middle. There seemed to be some injury to the bones of the chest; but not very serious. Behind the calf of the leg, the popliteal space and the lower part of the right thigh there was a continuous bloody contusion where he had been whipped against the wall. There was also a contusion of the left heel, which also had been whipped against the wall, with partial dislocation of the tarsal joint. Hemorrhage having been controlled by proper means, and stimulants and morphine administered, he was carried on a cot about one fourth of a mile to a room suitable for operation and treatment.

Scarcely had reaction from shock taken place (for the case was an urgent one) when, with the assistance of Doctors Browning and Baxter, I amputated the arm below the elbow. On the outer flap of the amputated arm was a contused wound. When the amputation was completed the second sound of the heart was not audible. Normal salt solution was

freely used hypodermatically. We then hastily and temporarily splinted and set the fractured limbs. Soon after this the pulse rose to 140 and the temperature to  $103^{\circ}$ . I remained with the patient until the next day, administering strychnine, digitalin and occasionally nitro-glycerine. He vomited occasionally during the whole night and part of the next day, when I gave 1 gr. of calomel every 2 hours for 4 or 5 doses, as the tongue was yellow. On account of alarming tympanites ten drop doses of turpentine were given every 5 or 6 hours; the bowels were also flushed out. Morphine and atropine were also administered as needed to relieve pain.

Of course in this state of low vitality union by first intention was not expected in the stump. On the 13th considerable blood was let out from under the flap of the stump, and the cavity washed out with peroxide of hydrogen solution: the dressings were applied and compressed by means of adhesive plaster and bandages. The patient was now put regularly on strychnine sulphat  $1/40$  gr. and quinine gr. iii every 4 to 6 hours—morphine as needed. Peptonoids and brandy or whiskey had been used from the beginning. On the 19th I found the skin under the right thigh, popliteal space and gastrocnemius muscle almost black. By friction and light massage upwards every day with liniments of different kinds, the skin in ten days regained its natural color.

Meanwhile the stump was suppurating badly, for which I used echthol internally until the amount of pus diminished.

It was on the 14th that the temperature fell to  $99\frac{1}{2}^{\circ}$  and the pulse to 88. I then directed patient to be fed liberally on eggs, milk and any good substantial and simple food which he might desire. On the 22nd, by passing the hand down the left fore-arm a bloody kind of fluid escaped from the orifice through which the bone had penetrated during the accident. A hole had ulcerated through the outside flap of the stump where the skin had been contused during the accident. He was also put on Tr. of the muriate of iron ten minims and chlorate of potash grs. v three times a day.



March 2nd. I sealed the orifice through the skin of the left forearm with comp. Tr. benzoin on absorbent lint, thus making an artificial scab. Up to March 22nd, on account of the frequent daily necessity of being lifted up by four or six persons for the purpose of defecation and the changing of the bedding, I had kept the fractured limbs in light loosely-fitting troughs made for the purpose and padded with absorbent cotton, so that his body could be handled without disturbing the relation of the ends of the fractured bones, as the patient was of course utterly unable to give any auxiliary help himself.

On March 22nd I encased the right leg and knee in a chalk and acacia bandage. On the 24th I encased the left arm and fore-arm in a starch bandage. On the 27th I put a starch bandage on the left leg and thigh. On the 28th, the hardened bandages having been cut and laced, I gave him permission to be put in a wheeled chair and pushed on the pavements. The next day he was placed in the chair and rolled to the centre of the town. Since that he has been driven about in the buggy. He can now bend and straighten his limbs, but not to the full extent, and can also bear considerable weight on his legs. He will soon have the use of all his limbs except the right hand which was amputated.

I am of the opinion that, after having been wound up to the chest on the shaft, the first revolution broke the left femur and the right leg against the wall which was two feet ( $23\frac{1}{2}$  inches) from the shaft, at the same time causing contusion of the left heel and injury to the tarsal joint. In the after revolutions the thigh was bent forwards on itself, and thus the lower left extremity escaped being lashed against the wall any more; hence less contusion of the cutaneous surface in this limb but the right limb having been fractured just below the knee, the unfractured length of that limb permitted it to be repeatedly lashed against the wall, and hence the greater contusion of the skin and underlying cellular tissue and muscles of that limb.

## REPORT OF CASES—CEREBRO-SPINAL MENINGITIS—HYDROPHOBIA.

DAVIS FURMAN, M. D., GREENVILLE, S. C.

At the last meeting of the Greenville County Medical Society, I reported a case of Spinal Meningitis which I had seen with Dr. Mauldin; and at that meeting I promised to furnish something on the subject to-day. Since that time it has been my lot to see with Dr. Giles another rare and if possible more interesting disease—a case of hydrophobia.

As the two diseases are in some respects analogous, in that "both come from the impenetrable domain of mystery;" that the pathological seat of each is in the brain and spinal cord; that the most conspicuous symptom of each is convulsion followed by paralysis; that alike they are refractive to medical means, and that of all diseases they inspire most universal terror—I shall give a brief report of both cases in this paper, and shall indulge in some general observations, especially with regard to the latter disease.

Case (1). On March 18, 1905, saw with Dr. Mauldin, W. R. K., aged 25. Family history of tubercle. Up to the last three or four months his health had been good. At that time he began to lose flesh, though at this time weight was 180 lbs. He had had one or two slight hemorrhages, and had given up business, hoping to recover his strength, though he was still able to get around very well. On March 17, while on the street, he complained of feeling badly; coming into the house he fell to the floor in a convulsion. When seen later his head was retracted; his spine was rigid; his arms were at right angles to the trunk; his legs were separated and half bent; his pulse was accelerated and his temperature was  $101^{\circ}$  F. After the convulsion he complained of great pain in the head and back. Later, when I saw him, the tonic spasms continued, and from time to time, especially when any attempt was made to move him, he had violent clonic spasms, often producing marked opisthotonos.

There was more or less twitching of the facial muscles and orbits; contraction of pupils, transient strabismus and limited but ataxic movements of the forearms and hands. His urine which was free from albumen, he passed voluntarily. There was no exanthem, herpes or roseolia on his body. The above symptoms growing gradually more severe, continued persistently to the time of his death, which occurred on March 21, five days from the beginning of the attack.

A careful consideration of the diagnostic criteria; the age of the patient; the suddenness of the attack and its short duration; the rigidity of the spine and the character of the convulsions, and the free use of the muscles of the jaws, and the marked hyperesthesia, pointed strongly to the theory that we had a case of epidemic-cerebro-spinal-meningitis. Yet the absence of rash, and the knowledge of the existence of a primary tubercular focus of infection led us to conclude that it was of tubercular origin.

Had spinal puncture been made, and a turbid fluid containing the diplococcus intracellularis been found, then the diagnosis would have been positive.

In an interesting article in the last number of the *Journal of the American Medical Association*, Dr. Cheney, of Cooper Medical College, California, in this connection, speaking of the frequency of this disease in children, and the fact that it is often mistaken for acute infections of intestinal origin, masked lobar pneumonia, typhoid fever, uraemia, the septic variety from middle ear disease or fracture of the skull, says it is certainly more common in infancy and childhood, but it can never be excluded as a possible diagnosis because the patient has passed a given age."

Case (2). On May 4, 1905, I saw with Dr. Giles, Vesta Heatherely, aged 4,—who presented unusual and alarming symptoms. Clinical history: On Sunday, April 30, 1905, she complained of slight malaise, though she went about as usual. She spent a restless night, and on the next morning symptoms were more pronounced. She was a little feverish, inclined to lie down, and in the evening, in spite of great thirst, manifested some great difficulty in swallowing. On Tuesday she was seen by Dr. Giles, who found her somewhat nervous, becoming much more so at any attempt to swallow liquids; and later in the day this symptom made it almost impossible to administer medicines. Temperature 101°—pulse 108. At 9 a. m., May 4, I saw her with him and noted the following symptoms: Facies—expression pinched and anxious; picking at nose, across the center of which was a large hyperaemic scar; from the left nostril exuded a frothy muco-purulent discharge; conjunctiva slightly congested; slight discrepancy of pupils which responded poorly to light; there was no rigidity of spine, jaws or arms. Hyperaesthesia marked. Temperature, taken with difficulty in axilla, was 101½° F; pulse 120.

On being asked if she was thirsty, she replied in the affirmative, became agitated and said, "But I don't want to drink now." When the liquid

was presented, the nervousness increased to a rigor, and as the cup was brought to her lips, with a fearful effort her mouth was thrown wide open and with a sudden spasmodic movement the edge of the cup was convulsively caught between the teeth and as the water entered her mouth, a violent reflex spasm of the larynx and a general convulsion, interrupted and jerky occurred. With a gurgling, choking noise the fluid, with a quantity of frothy mucous, was ejected and ran from her mouth during and after the convulsion. The duration of these convulsions was one or two minutes, after which she gradually returned to consciousness, to remain so until liquid was again presented. Even when she was just regaining consciousness, the presence of liquid provoked immediately a condition similar to what has just been described. In the afternoon of the same day I saw her again. By this time the psychic disturbance was much increased; the interval of lucidity was much shortened, yet even at this time she was sufficiently intelligent to apologize to her mother for striking her, which she did as each convulsion passed off.

At this time not only liquids, but flashes of light, sudden noises or movements provoked convulsions, laryngeal spasms, dyspnoea and copious discharges of frothy mucous from the mouth.

Temperature reached 104° F; pulse 140, irregular and dicrotic.

It was not my privilege to see the case to its close, for when our prognosis was made known we were summarily dismissed and another physician took charge. I may say, parenthetically, I am reliably informed that this doctor made a diagnosis of worms. His attempt to force down "worm tea" being frustrated, he determined to control the "fits" by a hot bath, the effect of which was to bring the case to a speedy conclusion by violent, persistent convulsions.

Being the first case of its kind I have seen, it was of greatest interest to me in all of its phases. One point of special interest was the very protracted incubation period.

The scar on the nose was the result of a bite inflicted by a dog not supposed to be rabid, which had wandered from a neighbor's house and disappeared after the bite. This occurred on January 1, 1904—16 months before the development of any symptoms. On the incubation period of hydrophobia authorities differ—most of them put it from three weeks to four months, while some place it at possibly two years.

As to treatment: beyond the most powerful antispasmodics to ameliorate the se-



verity of the convulsions, nothing known to medicine is of the least value, after the development of the disease. The management therefore resolves itself purely into a question of prophylaxis. The suspicious wound should, if on an extremity, be tightly bound, thoroughly washed, and to it caustic should be freely applied. After that the preventive inoculations of the nearest Pasteur institute should be advised. The disease is due to an unknown organism conveyed to man most frequently by the bite of the dog; sometimes by the bite of other carnivora. It behooves us, therefore, to know something of the evidences that indicate its presence in the lower animals.

In the report of the U. S. Bureau of Animal Industry, Dr. Salmon shows that the disease is largely on the increase in this country.

There are two varieties of rabies, the Furious and the Dumb; in both there is, (1), A period of melancholy or depression; (2), A period of restlessness or irritability, and (3), A period of paralysis.

From onset to the end, when he dies, the period is about eight days. Symptoms: During 1st period, he is anxious and restless; often hides from his master; obeys sullenly; changes position frequently; may or may not lose appetite, although it soon fails. He may show undue affection, licking everything in sight, or he may bite everything in reach, or may swallow all sorts of foreign bodies.

(Second). The period of irritability persists three or four days; during this he is spasmodically mad; has an irresistible impulse to run away. The (Third) or paralytic stage is characterized by a hanging jaw from which saliva drops; by glaring eyes and a staggering gait and finally complete paralysis. In Dumb rabies the characteristic 2nd stage may be entirely absent. Reports from many States show that dogs afflicted with this disease are often taken to veterinarians, supposed to be suffering with a bone in the throat.

Dr. Salmon says if a dog has difficulty in swallowing, or having wandered from home, returns dirty, exhausted and mis-

erable, he should be put under lock and key. Also "beware of the dog that becomes listless and hides away; is prowling in habit or walks about with his head down like a bear."

Of the popular errors on the subject there are many. As to the "mad-stone," it is worthy of no more consideration than other voodoo methods.

The popular belief, says Dr. Roswell Park, upon which the name is founded, that hydrophobia in all animals is characterized by abhorrence of water, has long since been proved erroneous. On the other hand, the dog is thirsty and sometimes very fond of water, even thrusting his head into it, although he may have difficulty in swallowing, or convulsions from so doing. There is a popular belief also that certain seasons predispose to its development, yet the observation of a great many veterinarians in this country and Europe show this to be entirely without foundation.

Another popular misapprehension is that rabies is a disease of spontaneous origin.

"Of all animals, the dog is most often the victim of the disease," therefore to eradicate it depends on the enforcement of stringent measures with regard to muzzling dogs permitted to go at large. The history of the disease in Sweden, Germany, Austria, Holland and England, where proper measures have been adopted, demonstrate the value of this method. Time and your patience will not permit me to go extensively into these reports, but as the experience in England is of especial interest, I will quote from Fleming's report: "The value of the muzzle in suppressing rabies has been perhaps best demonstrated in London on several occasions, and especially in 1885. In the previous year hydrophobia had increased to a very alarming extent in England, and no steps worthy of note had been taken to check the mortality. For London alone, no fewer than 27 deaths were reported as due to the bites of rabid dogs. A muzzle order was then enforced, and at the end of 1886 not a death was recorded.

"Unfortunately the order prescribing

the use of the muzzle was then rescinded, and in a few months a case of hydrophobia occurred in the south of London, soon to be followed by others, and, in 1889, ten deaths were registered.

"In July of that year the muzzle order was again issued and stringently carried out, and rabies and hydrophobia once more disappeared. In the whole of Great Britain the results from enforcing the muzzle order have been phenomenal, both in the opposition encountered by the authorities, and in the successful eradication of the disease.

"The number of rabid dogs officially reported was in 1887, 217; 1888, 160; 1889, 312. In the last mentioned year muzzling was adopted, and the number of cases fell to 129 in 1890, 79 in 1891 and 38 in 1892. Then owing to persistent opposition, muzzling was stopped, and the effect of withdrawing this measure was at once seen in the increase of rabies. In 1893 there were 93 cases, in 1894, 248, and in 1895, 672. At this point, owing to public alarm, muzzling was again enforced, reducing the number of cases in 1896 to 438, in 1897 to 151, in 1898 to 17, in 1899 to 9.

"As no case was discovered from Nov., 1899, to March, 1900, it was believed by the veterinary officers that the disease had been extinguished from Great Britain."

We are surprised, after such demonstrations, at such weak and dangerous vacillation on the part of our English neighbors. How much better are we doing in this land of boasted progress? And on whose shoulders does the blame rest?

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**MINUTES OF THE MEETING OF THE  
STATE BOARD OF HEALTH,  
MAY 12th, 1905.**

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The third meeting of the State Board of Health for 1905 was held in the office of the Secretary of State, at Columbia, on May 12th.

The following members were present:

T. Grange Simons, M. D., chairman, Charleston.

Robt. Wilson, Jr., M. D., Charleston.

Charles M. Rees, M. D., Charleston.

A. A. Moore, M. D., Camden.

W. H. Nardin, M. D., Anderson.

George R. Dean, M. D., Spartanburg.

Hon. U. X. Gunter, Atty. General, Columbia.

Hon. A. W. Jones, Comp. General, Columbia.

James Evans, M. D., secretary, Florence.

The meeting was called to order by the chairman, Dr. T. Grange Simons, and the secretary, Dr. James Evans, was requested to read the minutes of the last meeting which was held in Greenville, on April 11th, 1905. The minutes were read, and confirmed on motion of Dr. Dean.

At the formal request of the State Board of Health, at the meeting held in Greenville, on April 11th, 1905, the Atty. General was requested to prepare and have printed, a circular containing the recent Act of the Legislature in regard to compulsory vaccination, and embodying such rules and regulations for its proper enforcement as in their judgment was thought proper. In accordance with this request, the Atty. General presented the following circular,\* which was approved, ordered printed and distributed among the agents of the State Board of Health in all of the counties of the State. Dr. Dean moved that the Secretary of the Board be directed to have printed 10,000 copies of these circulars.

The chairman, Dr. T. Grange Simons, announced the reorganization of the Standing Committees of the State Board of Health, and read the names of the

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\* This circular appeared in the June issue of the *Journal*.



chairmen and the members of the Board comprising these committees. Dr. Dean moved that he be excused from serving as chairman of the Committee on Endemic and Epidemic Diseases to which he had been appointed. He was not excused. Copies of these Standing Committees were directed to be sent to each member of the Board.

Standing Committees of the State Board of Health:

Ordinances and Sanitary Code: Dr. Robt. Wilson, Dr. W. H. Nardin and Atty. General Gunter.

Endemic and Epidemic Diseases: Drs. G. R. Dean, A. A. Moore, and Robt. Wilson, Jr.

Registration of Vital Statistics: Drs. James Evans, A. A. Moore, and Atty. General U. X. Gunter.

Quarantine: Drs. C. M. Rees, Robt. Wilson, Jr., and Atty. General U. X. Gunter.

Sanitary Condition of State Penal and Charitable Institutions: Drs. W. H. Nardin, Comp. General A. W. Jones, and Atty. General U. X. Gunter.

Sanitary Inspection of Schools: Drs. Robt. Wilson, Jr., W. H. Nardin, and James Evans.

Local and Sub. Boards of Health: Drs. James Evans, W. H. Nardin, and Atty. General U. X. Gunter.

Dr. Simons presented his report to the Conference of State and Provincial Boards of Health, and the Conference of the State Board of Health with the U. S. Public Health and M. H. Service, at Washington, D. C., on May 15th, 1905.

Dr. Chas. M. Rees moved that the Board adjourn, to meet the 2nd Wednesday in October, 1905.

JAMES EVANS, M. D., Sec'y.

## TWENTY-FIFTH ANNUAL REPORT OF THE EXECUTIVE COMMITTEE OF THE STATE BOARD OF HEALTH TO THE SOUTH CAROLINA STATE MEDICAL ASSOCIATION, APRIL, 1905.

The Executive Committee of the South Carolina State Board of Health would respectfully submit their twenty-fifth Annual Report to the Association.

Your Committee have had much to contend with in coping with the wide spread epidemic of Small Pox in every part of the State. The violence of the disease is more marked, and with an overpowering increase in the death rate. This has, perhaps, been the means of awaking our legislative bodies, and we have at last secured the passage of an Act with regard to Compulsory Vaccination. The Legislature also passed a law compelling the report of communicable diseases, and the proper measures of quarantining, and other restrictive measures to be employed by the physician in charge of the sick. With regard to compulsory vaccination, we feel that we can now cope with Small Pox. The Bill provides for the passage of Municipal Ordinances, and Vaccination and Re-Vaccination must be performed at certain ages. Municipal Authorities, School Boards, Parents and Guardians, are all required to conform to the law as to the vaccination of all children outside of corporate limits. The direction and enforcement of vaccination is under control of the State Board of Health. The treatment of Small Pox and the failure to vaccinate those exposed by Physicians employed by the State Board of Health has been most unsatisfactory, and the Board of Health will now have in each County one agent or physician, upon whom we can rely. The State Board of Health is required to supply pure Bovine Virus to all who need it. The cost of vaccination must be borne by the County and Municipal authorities. We hope by proper selection of active agents, who will enforce this law, that we can report results. The immediate report of the existence of Small Pox to these agents, in each County, will lead to prompt measures of relief, and also secure us from waste of Vaccine Virus that must now be.

The General Assembly also authorized the State Board of Health to transfer, by sale or lease, the control of the Quarantine Service of the State, with the several Quarantine Stations, to the National Government. The Acts of Congress, Feb. 15th, 1893, allows the United States Public Health and Marine Hospital Service to assume control, when the proper State Authorities shall tender to them the Quarantine Service of the

State. The Bill passed by the Legislature of South Carolina was copied from the Florida Act, by which control of the Quarantine Service of that State was transferred to National control. The Bill was prepared by the Attorney General, from a copy sent the Chairman of the State Board of Health by Dr. J. Y. Porter, Health Officer of Florida, and after correspondence with Surgeon General Wyman, of the Public Health and Marine Hospital Service. This Bill retained the right of the State to protect herself from the presence of vessels that may be regarded as a menace to health, and also had some reserved rights as to State Health Officials. Surgeon General Wyman declined to accept the Quarantine Service, unless unconditional control was given. These conditions could not be complied with, unless so directed by the State Statute, and the matter remains unsettled.

With the march of improvement and progress, that is so evident in all parts of the State, we note with interest, the attention to Municipal Sanitation, and the development of improved methods in Public Water Supplies and Sewerage. Much remains, however, to be done, and attention to the pollution of streams must soon require legislation on account of the growth of our towns, and the discharge of household waste into streams that must soon be the available source of water supply to a large part of our population. Such discharge of Sewerage and the waste of Dye Works and Factories into streams render them less fit for use. True filtration should be employed for all river water, yet the methods of purification can be simplified, if the pollution is prevented by timely and efficient legislation.

T. GRANGE SIMONS, M. D.,  
Chairman Executive Committee State Board of Health.

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**REPORT OF THE SOUTH CAROLINA  
STATE BOARD OF HEALTH TO CON-  
FERENCE OF STATE BOARDS OF  
HEALTH WITH U. S., P. H. AND MA-  
RINE HOSPITAL SERVICE, WASH-  
INGTON, D. C., MAY 15, 1905.**

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The South Carolina State Board of Health, in accordance with request contained in circular letter of March 31st, 1905, from Surgeon General Wyman, would report:

There has been during the past year greater interest shown in Sanitary work and advances made in State and Municipal legislation. Among the most important was the Bill passed by the

General Assembly in regard to "Compulsory Vaccination," and provides that "All incorporated Cities and Towns in the State shall provide by ordinance for the vaccination and re-vaccination with pure bovine virus," and the State Board of Health shall establish the periods of time within which vaccination and re-vaccination shall be required, and provides penalties for neglect to obey or for violations of said ordinances.

The State Board of Health to have the general direction and supervision of vaccination in all parts of the State, and shall provide for carrying out the measures for vaccination outside of incorporated towns, and to establish and maintain proper quarantine.

Superintendents and Commissioners of Schools and Colleges to require proper evidence of vaccination prior to the enrollment of all scholars. County Commissioners and other officials, parents or guardians, are also required to comply with the ordinances as to vaccination and re-vaccination.

The State Board of Health shall keep and furnish fresh bovine virus for the use of cities and towns and individuals, free of cost.

Legislation has also been secured to regulate the sale of drugs and medicines by Peddlers and Itinerants. A separate license is required in each county, and the formula of the remedy or medicine is to be plainly printed on each package or bottle.

A Bill to require all villages, towns and cities to have and maintain a Board of Health, under the direction of the State Board of Health, and requirements as to the notification of all communicable diseases, and the proper use of restrictive measures to prevent the spread of such diseases, outside of such corporations. The attending Physician is required to report such cases to the nearest Board of Health, and to carry out the necessary protective measures.

The Medical Practice Act has been amended and some advantages secured.

The State Legislature also empowered the State Board of Health to negotiate with the U. S. Public Health and Marine Hospital Service for the transfer of several Quarantine Stations and control of the service. The Act was framed in accordance with that by which the State of Florida transferred the State Quarantine Service to the general Government, and accorded with Section 8 of the Act of Congress, February 15, 1893, but objection has been urged by Surgeon General Wyman, and the matter remains unsettled. The State, however, made the usual appropriations, and the Quarantine Service of the State is efficiently maintained.

We are glad to note legislation as to Municipal Sanitation.



Charleston has the promise of a full and satisfactory water supply. Columbia, Georgetown, Laurens, Darlington, Sumter and Anderson each have improved or introduced sewerage systems and water supplies.

Around Charleston the Sanitary Drainage have rendered most efficient service, and large areas of swamp land have been drained and valuable farming lands secured, and the health of these regions improved by such drainage.

Small Pox has prevailed in many sections of the State for the past five years, but at last legislation has been secured, and we trust progress may now be made in stamping out the disease.

Respectfully,  
T. GRANGE SIMONS, M. D.,  
Chairman S. C. State Bd. of Health.

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#### SOME ANSWERS GIVEN BY APPLICANTS FOR LICENSE TO PRACTICE, AT THE RECENT STATE BOARD EXAMINATION.

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At the last meeting of the State Medical Examining Board a resolution was passed that some of the questions and answers given before the Board should be published in the *Journal* of the Association, so that the incompetency of some of the men who come before the Board may be shown. Some of the questions and answers under Chemistry, Physics, Practical Urinalysis and Microscopy, were as follows. The orthography has not been changed.

Question.—Describe the action of electrolysis in the tissues.

Ans.—Electrolysis of the tissues aid in the sustenance of life and tenacity of the tissues.

(2). Electrolysis has a stimulating & exhilarating effect upon the tissues.

Question.—What constitutes potable, soft and hard water and how is the presence of chlorides detected.

Ans.—Potable water is water that can be carried around. in other words some localities have their supply gotten from elsewhere & the water must be one that is of good quality.

(2). Potable water is constituted H O, Sulph Iron, Arsenic magnesium lithium,

(3). Magnesia constitutes soft water Amon-

ia constitutes hard water. Chlorides may be detected by analysis by evaporation.

Question.—How would you test pure chloroform.

Ans.—In testing of chloroform by the adding of pure lime to it will take down a reddish brown collar if it is pure.

(2). It is tested by the adding of methian blue and it will turn of a blueish color.

(3). By analysis by evaporation.

(4). Sulphuric acid alcohol & CH CL<sub>3</sub>, heat gives a peculiar pleasant odor of acetones. Analid KoH—& CHCL<sub>3</sub> give a peculiar disagreeable odor.

Question.—Why is the term sulphuric ether incorrect.

Ans.—An ether is the hydrogen of hydroxyl replaced by alcohol, and if it is replaced by sulphur or sulphuric acid it is not an ether then.

(2). By the term sulphuric ether is incorrect by the expressing of the sulphuric acid that it contains and expressing the poisoned conditions that it contains.

Question.—How are uric acid crystals deposited and what is their morphology.

Ans. Uric acid crystals are deposited by setiment.

(2). In gravel we would find epithelium, blood, soda. In calculus we would find bile and urates.

(3). They are deposited in round, hexagonal crystals which are very hard.

Question.—What does continued low specific gravity in the early morning urine indicate.

Ans.—Diabetes melitus early in the morning. 1 to 7 o'clock Sugar in the urine.

Question.—When might the solid constituents of the urine be normally absent.

Ans. After a meal of sweets.

(2). Sp Gr, absent in the morning after nights rest there no muscular exercise has been taken and no eating done, where the body has been at perfect rest for over eight hours.

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#### THE KERSHAW MEDICAL SOCIETY.

The Kershaw Medical Society was organized in 1866, under the name of "The Kershaw County Medical Association." In a fire in Camden a few years since, the records were burned, but there are a few copies of the Constitution adopted, and officers elected for the year 1866. The officers elected were:

Dr. L. H. Deas, President; Dr. J. J. Trantham, Vice-president; Dr. A. A.

Moore, Recording Secretary; Dr. A. A. Johnson, Corresponding Secretary; Dr. Andrew Burnet, Treasurer.

Standing Committees for 1886:

*I. Science and Progress of the Profession:*

Dr. L. M. DeSaussure, Dr. C. J. Shannon, Dr. Wm. L. Pickett, Dr. S. Baruch, Dr. R. Y. McLeod.

*II. Grievances and Appeals:*

Dr. C. J. Shannon, Dr. D. L. DeSaussure, Dr. Thomas McDow, Dr. T. W. Salmond, Dr. J. A. Glenn.

*III. Printing, Finance and Claims:*

Drs. A. A. Moore, D. L. DeSaussure, and T. W. Salmond.

A further list of members is not to be found. Of these, Dr. Baruch, now of New York, is well known. Dr. Moore is the genial gentleman known well in our State Society.

Dr. D. L. DeSaussure lives in Camden, and Dr. Glenn lives at his home in the county. The others are now at rest. The Kershaw County Medical Association has been in active existence ever since its organization, and was reorganized last January, to conform with the State Association.

The original Constitution provided for quarterly meetings, with an essay by some member and a general discussion. At the next meeting, July 11, 1905, an essay on "Typhoid Fever" will be read by Dr. J. W. Corbett.

The officers and members of the Society at present are as follows:

Dr. W. J. Burdell, President.  
Dr. A. W. Burnet, Vice-President.  
Dr. S. C. Zemp, Sec. and Treas.  
Dr. A. A. Moore, Ex-Pres.  
Dr. J. W. Corbett, Ex-Pres.

Dr. D. L. DeSaussure.  
Dr. W. J. Dunn.  
Dr. S. C. Brasington.  
Dr. W. R. Clyburn.  
Dr. J. T. Hay.

## COUNTY NEWS.

DORCHESTER.—The Dorchester County Medical Society met at St. George's, in the dental office of Dr. McRae Johnston, on Monday, July 3rd, 1905, at eleven o'clock a. m. While the attendance was not as large as could be desired, the meeting proved to be very interesting and instructive. Drs. LeGrand Guerry, of Columbia, and M. G. Salley, of Orangeburg, were present by special invitation. Dr. J. B. Johnston nominated for membership Drs. M. G. Salley, of Orangeburg, and A. A. Horger, of Harleyville. On motion of Dr. J. P. Mellard, the rules were suspended, and they were elected by acclamation. Dr. J. P. Mellard, the essayist of the meeting, read a very excellent paper on "The Use of Alcohol in Medicine."\*

Dr. Guerry gave an admirable address on "Operation for Radical Cure of Inguinal Hernia." It was a plain, practical address, especially adapted to the needs of the general practitioner, and was greatly enjoyed. The thanks of the society were extended to Dr. Guerry, on motion of Dr. Mellard.

The society adjourned, to meet at St. George's on the first Monday in August, at 11 o'clock a. m.

Before returning home, Drs. Guerry and Salley, accompanied by Drs. J. P. and A. R. Johnston and Mr. C. M. Whetherell, of Reevesville, and Clerk P. C. Johnston, Jr., of St. George's, spent a pleasant

\* This paper will appear in a future issue of THE JOURNAL.



afternoon on the Edisto River. The feature of the occasion was a delightful fish-fry. The Dorchester County society congratulates itself upon the valued accession of Dr. Salley to its roll of members.

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### MARRIAGES.

On June 21st, 1905, Dr. E. O. Devlin, of Verdery, S. C., to Miss Mae Donald, of Greenwood, S. C.

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On June 14th, 1905, at eleven o'clock, Dr. John Lyon to Miss Emma Hill, both of Ninety-Six, S. C.

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### DIRECTORY OF COUNTY SOCIETIES.

Abbeville, Sec. Dr. C. C. Cambrell, Abbeville, S. C.

Aiken, Sec. Dr. W. C. R. Turnbull, Aiken, S. C.

Anderson, Sec., Dr. J. B. Townsend, Anderson, S. C.

Bamberg, Sec., Dr. J. J. Cleckley, Bamberg, S. C.

Barnwell, Sec., Dr. L. F. Bonner, Blackville, S. C.

Beaufort, Sec., Dr. M. G. Elliott, Beaufort, S. C.

Berkeley.—Not organized.

Charleston, Sec., Dr. J. C. Mitchell, Charleston, S. C.

Cherokee, Sec., Dr. B. L. Allen, Gaffney, S. C.

Chester, Sec., Dr. W. B. Cox, Chester, S. C.

Chesterfield,—Not organized.

Clarendon, Sec., Dr. L. C. Stukes, Summerton, S. C.

Colleton, Sec., Dr. Chas. Es Dorn, Walterboro, S. C.

Darlington, Sec., Dr. J. C. Lawson, Darlington, S. C.

Dorchester, Sec., Dr. J. B. Johnston, St. George's, S. C.

Edgefield, Sec., Dr. J. G. Edwards, Meeting St., S. C.

Fairfield, Sec., Dr. R. B. Hannahan, Winnsboro, S. C.

Florence, Sec., Dr. F. H. McLeod, Florence, S. C.

Georgetown, Sec., Dr. Olin Sawyer, Georgetown, S. C.

Greenwood, Sec., Dr. R. B. Epting, Greenwood, S. C.

Greenville, Sec., Dr. J. R. Ware, Greenville, S. C.

Hampton, Sec., Dr. C. A. Rush, Hampton, S. C.

Horry, Sec., Dr. J. A. Norton, Conway, S. C.

Kershaw, Sec., Dr. S. C. Zemp, Camden, S. C.

Lancaster, Sec., Dr. J. E. Poore, Lancaster, S. C.

Laurens, Sec., Dr. R. E. Hughes, Laurens, S. C.

Lexington, Sec., Dr. J. J. Wingard, Lexington, S. C.

Marion, Sec., Dr. E. Marvin Dibble, Marion, S. C.

Lee, Sec., Dr. L. H. Jennings, Bishopville, S. C.

Marlboro, Sec., Dr. J. H. Reese, Tatum, S. C.

Newberry, Sec., Dr. J. G. McMaster,  
Newberry, S. C.

Orangeburg,—Not organized.

Oconee, Sec., Dr. D. L. Smith, Newry,  
S. C.

Pickens, Sec., Dr. H. E. Russell, Easley,  
S. C.

Richland, Sec., Dr. Mary R. Baker, Co-  
lumbia, S. C. (Columbia  
County Medical Co.)

Saluda, Sec., Dr. J. D. Waters, Coleman,  
S. C.

Spartanburg, Sec., Dr. O. W. Leonard,  
Spartanburg, S. C.

Sumter, Sec., Dr. Walter Cheyne, Sum-  
ter, S. C.

Union, Sec., Dr. Theo. Maddox, Union,  
S. C.

Williamsburg,—Not organized.

York, Sec., Dr. J. R. Miller, Rock Hill,  
S. C.

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#### INFLUENCE OF BICARBONATE OF SODA UPON THE COURSE OF THE INFECTIONS.

M. Auerbach, in the laboratory of Prof. Reprew, of Karkoff, has devoted some interesting experiments to this problem. After having established that bicarbonate of soda, at a sufficiently high temperature, exercises *in vitro* an incontestably bactericidal action, he produced in animals several experimental infections (typhoid, staphylococcus), and sometimes allowed them to develop without medication, sometimes subjected the infected animals to the action of bicarbonate of soda. In

all these experiments the control animals succumbed, while the animals treated with bicarbonate of soda resisted the infection, the clinical symptoms of which were moreover remarkably attenuated.

These experiments possess a very great interest and are susceptible of an immediate practical application. During a typhoid or a grip epidemic, etc., they suggest to us a useful means of augmenting the resistance of the organism by the employment of bicarbonate of soda, or better by the substitution of a mineral bicarbonate of soda water for ordinary table water or an indifferent mineral water. The choice of this water will be determined by the subject's state of nutrition.—*Le Progress Medical*, May 7th, '05.

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#### CONCERNING SNAPSHOT DIAGNOSIS.

One of the temptations which come to the clinician of even moderate experience is the tendency to make diagnoses on sight, the so-called "snapshot" diagnoses. The innate desire to play to the gallery which is present to some extent in most of us, as well as the wish to appear preternaturally brilliant in the eyes of the public or the student, is the cause of this temptation. Even the most conservative among us gets into the habit of making subconscious snapshots when he almost unconsciously sizes up a patient at his first visit. While such diagnoses are occasionally justified, they are, in the long run, severely to be condemned. Certain diseases are, in their well-marked forms, so characteristic that even a tyro can



hardly fail to recognize them. A number might be mentioned, acromegaly, exophthalmic goiter, myxedema, and osteitis deformans among the rest. But it is in the fruste forms of just these diseases that diagnosis may be most difficult. The habit is one which, in the long run, leads to careless observation, and while it leads to a few brilliant diagnoses, causes many regrettable mistakes. The humorous side of the matter is well illustrated by a story recounted by Byrom Bramwell in a recent

address. A physician who was very great on physiognomic diagnosis in going through the wards one day directed the attention of his students to the teeth of a patient, saying that they were splendid examples of gouty teeth. The patient, seeing that the professor was so much interested, took the teeth out and handed them to him, asking if he would like to examine them more closely. A word to the wise is sufficient.—*Journal Am. Med. Assn.*

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# Medical College of the State of South Carolina.

CHARLESTON.

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## Medicine and Pharmacy.

FOUNDED 1823.

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For announcement address

**Dr. FRANCIS L. PARKER, Dean,**

70 Hasell Street,

CHARLESTON. S. C.


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# The Journal

OF THE

## South Carolina Medical Association



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## South Carolina Medical Association

Next Annual Meeting at Columbia, S. C., April 18th, 1906.

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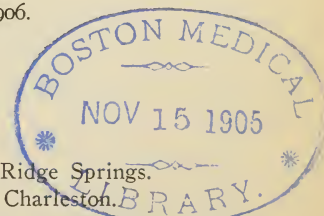
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*Sixth District,* F. H. McLEOD, M. D.....Florence





# Medical College of the State of South Carolina.

CHARLESTON.

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## Medicine and Pharmacy.

FOUNDED 1823.

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For announcement address

**Dr. FRANCIS L. PARKER, Dean,**

70 Hasell Street,

CHARLESTON. S. C.

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CHARLESTON, S. C., Aug. 15, 1905.

Dear Doctor :

This is to inform you that I now occupy my new store northwest corner of Meeting and Columbus streets, opposite my old stand.

It is my intention to carry a more complete line of drugs, Pharmaceuticals and Chemicals. It will be my endeavor to give entire satisfaction both to you and your patient.

I thank you for the favors of the past and ask a continuance in the future.

Very truly,

W. L. SPEISSEGGER.

# THE JOURNAL

OF THE

## SOUTH CAROLINA MEDICAL ASSOCIATION.

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4 Vanderhorst Street, Charleston. S. C.

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ROBERT WILSON, Jr.,  
Editor.  
C. P. AIMAR, Managing Editor.

T. P. WHALEY,  
Associate Editor.

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ANNUAL SUBSCRIPTION, \$2.00.

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THE JOURNAL is published monthly under the auspices of the South Carolina Medical Association. Members who do not receive their copies will please notify the Managing Editor at once. Secretaries of county societies are requested to send reports of their meetings, and items of news that may be of interest to the profession. Original articles are solicited. Articles should be type-written; and illustrations sent with articles will be printed at the expense of the writer. Reprints will be furnished at the rate of 75c. a page for a hundred pages.

All matter must be in the hands of the editor by the 10th of each month.

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### EDITORIAL COMMENT.

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#### THE PORTLAND MEETING OF THE AMERICAN MEDICAL AS- SOCIATION.

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*The President's Address.*—After reviewing the history of the Association Dr. McMurtry discusses the new plan of organization which has now been in operation for four years. The influence of the reorganization "was immediately apparent in the increased attendance at the annual sessions, and the stimulus felt in every purpose of the Association." One of the prime purposes of the organization is to promote professional and individual development by bringing physicians into contact with one another. "The physician, more than any other professional man, is isolated by the conditions of his life, and to no profession is the educating influence of society work so essential and invaluable. . . . The

lonely worker in any calling is prone to become narrow, suspicious, and morbid. Our medical societies are the great post-graduate schools of the profession, where knowledge is increased and individual character developed." These words have a forceful application to our own local conditions. The announcement is made that "all the states and territories, except three, including Hawaii and Porto Rico," have entered into the revised plan of organization. In Michigan the membership increased in one year from 452 to about 2,100, and in Texas the gain was from 382 to 2,510 in the same period of time. "The possibilities of this work are stupendous." The other topics discussed are Medical Education, Medical Legislation, and the Council on Pharmacy and Chemistry. All right-minded physicians will assent to these words: All proprietary medicines must not be classed as secret nostrums, for there are many honestly made and ethically advertised proprietary preparations that have therapeutic value and that deserve the approval of the medical profession. But there are many preparations offered the profession, which are protected by copyright or trade-mark, with formulae more or less fictitious, and for which are made extravagant claims, which are in fact secret remedies. . . .

The use of such remedies is both unscientific and unjust, alike to physician and to patient." It is for the purpose of handling this most important matter that the Council on Pharmacy and Chemistry has been established, and it will doubtless be fruitful of great results.

*The House of Delegates.*—The meeting of the House of Delegates was one of the most successful ever held. The Secretary reported a net increase in membership of 3,951, making a total of 19,285. The American Medical Association is now one of the largest medical organizations in the world. One of the most important committee reports was that on Medical Legislation. It is the aim of this committee to effect an organization which shall have a correspondent in every county in the United States. The committee is "now in possession of a directory em-



bracing about 2,800 local correspondents." This great organization has already been "most effective in bringing the influence of the medical profession and, through the medical profession, the influence of the respective communities to bear on such questions as legitimately concern not only the medical profession, but the public at large." Notwithstanding the unfavorable opportunity offered at the last session of the 58th Congress the influence of the committee succeeded in bringing under consideration three important measures, one of which, that for the establishment of an Army Medical Hospital in Washington, was passed. At the next Congress several measures of interest to the profession will be considered. Among these will be the pure food and drug bill and the Medical Reorganization Bill. Probably measures in behalf of a naval hospital, and recommendations as to the modification of the status of the medical department of the Navy will also be introduced. It is the wise policy of the committee "to champion only a few bills but good and necessary ones rather than to divide its energies in promoting a number of measures some of which may be of questionable benefit." The vast power for good which the work of this committee may develop will sufficiently impress itself upon every one and we need hardly add that it merits the hearty co-operation of every society in every state.

The secret nostrum evil was the subject of several resolutions and reports. The importance of this matter is so great that some of these resolutions and the action of the House of Delegates regarding them are printed in full in another column.

The Reference Committee on Education recommend as a minimum standard "a four years' course, each year of at least thirty weeks, with thirty hours per week of actual college work (exclusive of holidays)." They also recommend that "in the construction of a standard medical curriculum by the council provision be made for a distinct and complete course on business methods for the practitioner,

on medical ethics and the value of medical organizations."

We congratulate ourselves and the medical profession at large upon Dr. McCormack's consent to undertake for another year the important work of organization which he has carried on with such signal success in the past.

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#### YELLOW FEVER AGAIN.

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Once more the dreaded Yellow Plague has eluded the vigilance of the local health authorities and gained a strong foothold on American shores. The type of the disease is more virulent than in the last epidemic at New Orleans, but under proper management the mortality seems to be growing less. The conduct of the fight against the disease has been placed in the hands of the U. S. Marine Hospital Service and is being carried on upon the basis of the theory that a certain species of mosquito is the only agent concerned in its transmission. We have no doubt that the brilliant results achieved at Havana will be duplicated at New Orleans. But it is not enough to exterminate the disease in Louisiana. It should not be allowed to recur in the future. And in the light of the knowledge we have gained in recent years, we believe that this is easily possible. The requisites are an early and vigilant quarantine maintained throughout the mosquito season, the immediate screening of every suspect, and the thorough cleansing of our sea-port towns and cities in order to remove as far as possible the conditions which favor the propagation of mosquitoes. The latter requires a well organized health department, and the intelligent co-operation of educated physicians and an educated public. It can be done. Modern commerce demands that it shall be done.

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#### PENNYPACKER VETOES THE PENNSYLVANIA OSTEOPATHY BILL.

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Whatever else may be said of Governor Pennypacker of Pennsylvania, the Medical Profession of the United States will certainly accord him at least a modicum

of intelligence for his prompt, efficient and sage action in vetoing the Osteopathy Bill recently passed by the Legislature of Pennsylvania.

In vetoing this bill, the Governor has conferred a boon upon the inhabitants of Pennsylvania. • He has shown that he at least declines to acquiesce in the humbuggery of the public, from which this bill was framed.

He at least realizes that to grant a man permission to practice medicine and surgery, without granting him permission to use drugs, is a farce on its face, and a folly unsurpassed. He at least realizes that to give a man the privilege of treating diphtheria without allowing him to use its positive antidote, antitoxin, is criminal to say the least, and is equivalent to telling a surgeon to perform an operation for appendicitis without antiseptics, or without the use of instruments.

It is sincerely to be regretted that the Governor of South Carolina, the much esteemed Heyward, did not show an equal amount of wisdom when the Osteopathy Bill passed by the Legislature of 1904, and ratified by that of 1905, was presented to him for final action. Had he vetoed this bill, he would have shown that he had at least the interest of his people at heart, that he had at least the welfare of the many poor little tots suffering with this dread disease at heart, instead of consigning them to the care of the Osteopaths, who make claims that they cannot possibly fulfil, and who place their chances of recovery on the same plane that it rested one hundred years ago, viz., that forty out of every hundred shall die. We hope that the intelligence of the laity of South Carolina will not permit that number of cases to fall into their hands; but at the same time we must bear in mind that intelligence is a relative quantity.

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#### THE TEXAS STATE JOURNAL OF MEDICINE.

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We are in receipt of the first issue of the Texas State Journal of Medicine, which appeared last month. It is a splen-

did beginning and the State Medical Association of Texas has our sincere congratulations. May the high standard set by the initial number be always maintained, and the journal grow in strength and influence with each year.

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In the June issue we called attention to the indifferent manner in which the County Secretaries responded to a circular letter that had been mailed them. After a great deal of hard work, we have succeeded in getting responses from nearly all the County Societies, but as yet we have not heard from the following: Florence, Lancaster, Laurens, Orangeburg and Williamsburg. Some of these counties are, we understand, without an organization. We sincerely trust that they will get together and organize as soon as possible. In the meantime, we would request that some of our members, who reside in these respective counties, would send us a list of the reputable physicians in their County, as we would like to place the names so sent on our mailing list and send them copies of the *Journal*. We hope in this way to assist the Councilors in perfecting a permanent organization, that we may have in our State body every County in South Carolina.

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Physicians who have not yet returned the postal cards issued last month are requested to do so without further delay. Every member of the Association is *de facto* a bona fide subscriber to the *Journal*, but it is necessary to be able to show such a list and this method was resorted to as the simplest and easiest to meet the requirements. Please reply at once.

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“But in the whole scheme of readjustment nothing commands our sympathy and co-operation more than the making of the county societies, the materials out of which the State and National associations are built. . . . On the county members I would urge the support of a plan conceived on broad national lines—on you its success depends, and on you its benefits will chiefly come.”—*Osler*.



## ORIGINAL ARTICLES.

## REST IN THE TREATMENT OF LARYNGEAL AND PULMONARY TUBERCULOSIS.

W. PEYRE PORCHER, M. D.,  
CHARLESTON, S. C.

It is a well known fact that it is impossible to repair a watch while it is running. It is equally true that rest, partial or complete, is necessary to restore any diseased limb or impaired function or organ of the body. If the eye should be diseased we must rest that; if a limb should be wounded we must rest that; why, therefore should we not be equally stringent that a diseased throat should be rested?

By resting the larynx I mean total cessation of phonation. The amount of cough being limited by judicious local and constitutional treatment to the least possible quantity.

Certainly next to violent paroxysms of cough, and perhaps exceeding them, reckless and prolonged phonation does more towards destroying the laryngeal mucous membrane than any other factor.

We have all borne witness to this truism in the cases of preachers, lawyers, singers, hucksters and all those whose livelihood depends to a greater or less extent upon vocalization.

Never will I forget the impression made upon me many years ago by a preacher whose vocal integrity had been restored by a few months' rest in a mountain region. On his return home, after describing his trip to numerous friends, preaching, etc., he became entirely aphonic, and he early filled a consumptive's grave.

It is not alone in cases of laryngeal tuberculosis that complete rest of the larynx and pharynx is indicated. In ordinary pulmonary cases efforts to phonate excite hypersecretion and contraction of the laryngeal muscles. Therefore complete cessation of phonation will lessen the amount of cough and consequent prostration, hyperpyrexia, perspiration, etc. It

has been found that this absence of phonation does not result in ankylosis of the joints even after a period of several months. The explanation of this fact appears to be that in ordinary respiration there is still sufficient motion to prevent it, and it might be well for us to recall here that we are not concerned alone with the larynx, because we know that vocalization can be entirely destroyed by traumatism or other interference with the integrity of the pharynx.

During respiration or swallowing the laryngeal muscles are in a state of comparative rest, but in coughing or phonation every muscle is active. Hence, if the integrity of the mucous membrane of the larynx has been destroyed, rest, partial or complete, is imperative before the restorative processes might naturally be expected to set in.

It has been urged by many writers that cough up to a certain amount should be encouraged instead of hindered, in order that the bacilli may be ejected. A limited amount of cough may be said to be unavoidable in some cases to remove accumulated excretion, but certainly it should in no wise be encouraged; first, because the patient could derive but small benefit from the ejection of a certain number of bacilli when the tissues were left saturated with them, and second, because we cannot account for the manner in which nature absorbs or throws off the bacilli in some cases in which they appear to have disappeared.

Some Sanatoriums North and West have achieved great success by reliance alone upon the open air treatment, with almost total exclusion of all local and even constitutional medication. It would appear, therefore, that if such good results were to be obtained alone by the aid of atmospheric invigoration, that Nature was quite competent to take care of the bacilli: but if this is the truth, how much greater and quicker results should accrue with the aid of complete rest of the diseased organ combined with the judicious use of anodynes internally and local applications to heal intractable ulcers, etc.

It has been and still is advocated by

some laryngologists, that in order to obtain total and complete rest, the respiratory function should be abolished by the aid of tracheotomy. This would indeed be ideal were it possible to obtain such results by this measure. Unfortunately, however, apart from the infection of the wound by the bacilli, the secretions become agglutinated by the inflammatory exudates from the wound, the cough is aggravated thereby; liability to pneumonia is set up, and the effort to get rid of the sputa is rendered so difficult that the advantages gained are far more than offset by the disadvantages.

The great benefit derived from the non-use of the voice is so striking that no one can fail to appreciate it who watches the progress of a case. The simple effort to phonate is aggravated 10,000 per cent. when the larynx is whipped up to do its normal amount of work, namely, the overcoming of the noises of traveling, other voices, and the continuous effort to do even more than is ordinarily required of it.

A patient recently under my care reported that he had been coughing for over a year. He had been rooting at foot ball games, taking part in college sports and teaching school with the poorest hygienic surroundings.

Of five physicians who had attended him, none had urged him to discontinue the use of his voice. Severe infiltration of the entire laryngeal mucous membrane was found, but the arytenoid prominences were not enlarged nor was there any ulceration of the vocal chords or of the epiglottis. There was a marked dullness under left clavicle, loud vesicular murmur and engorgement at base of left lung as a result of old pneumonia. Tubercle bacilli were found in his sputa and he had a temperature varying from 99 to 101 degrees. On the slightest exertion his pulse ran up to 100 and over.

Complete cessation of phonation was exacted of him; he was given small doses of Dover's powder and quinine at night to secure sleep and an emulsion of turpentine and ammonia, with morphia sulph. grs. 1-6 ter, die. He also took at

intervals palmiacol, thiocol, beechwood creosote, and locally applications of a formalin solution 10% to the larynx. Occasional application of nitrate of silver was also made to the pharynx. He was ordered to drink milk in place of water and to eat as many raw eggs as he could assimilate.

As a result of this treatment, his symptoms have all abated, he has gained flesh steadily, the laryngeal inflammation has almost entirely disappeared, and he is deeply impressed with the benefit derived from the non-use of his voice.

It is interesting to note that the improvement in this case has taken place without any special reference to climate. He has not been sent off to the mountains nor required to sleep out of doors, nor to do anything else, except to keep fresh air in his room and to stay in when the weather was inclement. Had he failed to respond to this rest and conservative treatment, he would undoubtedly have left for some higher clime, as so many persons do who are deluded with the idea that their only chance of cure lies in a high and rigorous climate. Many of these unfortunates sacrifice all the care and attention they would receive at home for the discomforts and even privations which they often find unavoidable among strange surroundings. No case of tuberculosis should be allowed to leave home unless he can get every luxury usually obtainable only by the wealthy, with the care of a skilled nurse and medical attendant.

The chief advantage which patients obtain at Sanatoriums which they do not get from their home physicians is that more absolute control is exerted over them. Their daily out-goings and incomings are more closely watched. For example, the exaction of absolute silence by a home physician would be regarded as unnecessarily strenuous treatment even in the laryngeal cases, whereas it is no less indicated in the one than the other.

It is astonishing how many so-called cures have been recorded of laryngeal tuberculosis by different authors and under



different forms of treatment where patients were often allowed to follow their daily avocations, use tobacco, smoke cigarettes, etc., and yet no one denies the efficacy of complete rest to the throat, or that the effect of tobacco is injurious.

Failure to observe the precautionary measure of laryngeal and bodily rest in tuberculosis during any degree of pyrexia is simply criminal. This being the case, is it not equally indicated in the apyretic stage? By complete rest we increase the physiologic power of the patient to resist the disease and as there is no drug or serum so far discovered which has proved to be a panacea, we are forced to rely on rest, fresh air, good food, and those drugs which we now know limit all inflammatory processes. In conclusion, we must estimate the amount of advantage to be derived from rest and complete absence of phonation in tuberculosis of the respiratory organs. The violence and amount of cough determines the amount of injury done to those organs and the consequent amount of pyrexia.

Every symptom productive of cough is at variance with a return to health. Rest, either partial or complete, should therefore be paramount in all cases.

#### DISCUSSION.

DR. A. H. HAYDEN: I have listened with a great deal of interest to Dr. Porcher's paper. It is a paper which interests me at this time more, probably, than any paper I might hear read before this Association. I have followed him very closely, and noted, I hope with good results to myself personally, many little hints which he has given out, and I am not rising now to discuss the paper at all, but to ask for information. I would ask Dr. Porcher, before this paper is dismissed from the consideration of the Association, if he would give us some little information relative to diagnosis. I have a number of cases that come to me every winter. For the most part, I admit, the information is derived from the patient, but at present I have a patient on hand from whose physician in New York City I have a letter stating that the patient is suffering from laryngeal tuberculosis. I have examined his sputum microscopically, I do not think I err, when I say not less than ten times in the past five months. I am unable to find tubercular bacilli, and so far as tubercular laryngitis is concerned, I am unable to diagnose it unless the bacillus is in the sputa. I treat lots of cases, but unless I find the bacilli in the sputa microscopically I am unable to diagnose, and I don't believe many other men, except specialists, are able to diagnose a case of tubercular laryngitis. I ask that Dr. Porcher will

give us some few points in the diagnosis of this very important trouble.

DR. H. WYMAN, JR.:—The doctor's paper covers the subject very ably. I would like to know the exact amount he gives,—did I understand that it was 16, or 60 drops of creosote three times a day? And whether he administers it with water, whiskey, sherry, or with milk, before or after meals.

I have had some experience with tubercular patients, especially laryngeal tuberculosis, and the rest. I must say is very beneficial. One case came to me this winter, of a lady who came from the north, who could not speak at all, and her doctor advised her not to try to use her voice. She could articulate a little. She stayed in Aiken about four months, and was taken suddenly with colic, caused by something she had eaten for dinner. I was called in, and when I walked in she began explaining the trouble to me, and said, "I suppose you will be surprised to know that this is the first time I have uttered a word since I have been in Aiken,—under my doctor's orders, which I have observed rigorously, and I am surprised to see that I can talk." She told me then how long she had been sick, and the next morning she came to the office and told me she felt that if she tried to talk she would lose her voice entirely, but felt that the rest had restored her voice. That is one thing I think we should try and enforce on our patients.

As to diagnosis of tubercular laryngitis, I have had very little trouble in finding the tubercular bacilli. We might not find them in every case, but I think if we get the sputum, especially in the morning, coughed up before the patient has swallowed anything, we will be apt to get the bacilli. I have always found them that way.

DR. PORCHER:—In answer to Dr. Hayden's request, he has opened up quite a large subject; that is, the differential diagnosis between laryngeal tuberculosis and malignant disease of the larynx. Some cases resemble each other so greatly that it is an open question, if not almost impossible, to diagnose it by ocular demonstration, that is, by the use of the laryngoscope alone. I had such a case as that several years ago, and finally sent on a piece of a growth which appeared in her throat, which was pronounced finally to be tubercular. So the only method by which it can be absolutely diagnosed is finding the bacilli in the sputum. That is the only method I know and am governed by. Of course, we know that where you have a malignant disease in the larynx the diagnosis, in its incipency, is exceedingly difficult. We have recently heard quite a great deal on that subject before the American Laryngological Association, I believe started by Dr. John McKenzie, of Baltimore, who urged that the microscope, broadly speaking, be discarded entirely in the diagnosis of malignant laryngeal growths. I need not say that this provoked a heated argument and brought out expressions of different views. Dr. McKenzie advocated that no injury should be done to the laryngeal mucous membrane until the patient was willing to have every gland in connection with the throat absolutely and entirely removed. He said he thought the disease was aggravated by the removal of any portion of it, and he relied alone upon the open eye diagnosis. So whether it is tuberculosis or malignant disease, I rely on finding the bacilli under the microscope.

So far as the dose of creosote is concerned, which Dr. Wyman asked about, my rule has been to allow the patients to settle that for themselves. Some persons have great tolerance with regard to taking creosote. Persons have taken as much as 300 drops 3 times a day without apparently upsetting their digestion, but every case is a law unto itself, and is to be treated according to individual peculiarities. My reason for allowing this patient to take creosote at all was because I was urged to do so by a physician who came on from the north, one of the most distinguished in America, who said he had had such good results from pure creosote, he urged me to allow him to take it. This patient had been doing so well, that I was loath to do it, but at the solicitation of this doctor from New York, contrary to my own judgment, I allowed the patient to take it. He did so, and as I stated, rapidly ran it up to 60 drops 3 time daily. I don't know what he combined with it, but certainly not whiskey. Of course it was not the creosote alone which produced the indigestion. He undertook to suck three lemons, in connection with his supply of three quarts of milk a day, and a violent attack of indigestion was produced.

Therefore, the point I want to make is the application of complete rest in laryngeal tuberculosis and pulmonary tuberculosis. If any of these patients could be compelled to cease the use of the vocal chords, coughing would be lessened. I believe the other symptoms are due to prolonged coughs, therefore the more you control the cough the less discomfort the patient has, and I don't know of any way of controlling this cough as well as by controlling the use of the voice.

A few days ago I took this patient out for a drive in the early morning air, and attempted to entertain him, and after driving for two or three hours, I asked him if he didn't realize how much better off he was sitting there and not using his voice at all. If he had been attempting to talk, and to overcome the rattle of the buggy wheels and other noise around, he would have sat up and coughed, and one spell would produce another, and so on. I am satisfied if I hadn't stopped that man from using his voice when he first came under my care, instead of getting better he would have gotten worse, and would be now probably in the Adirondack Mountains, or somewhere else. He is now getting along very nicely.

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#### EARLY SYMPTOMATOLOGY OF GALL-STONES.

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A. B. KNOWLTON, M. D., COLUMBIA, S. C.

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Upon close study of the early symptomatology of those cases of gall-stone disease which have come under my observation and upon which I have operated, I am constrained to believe that in each case an earlier, and at the same time an equally positive diagnosis could have been made.

I conceive it be axiomatic that the ear-

lier surgical intervention is had after any disease is once positively demonstrated to be strictly surgical, the better will be the physical condition of the patient for operation, the fewer will be the complications and sequelae and the easier and safer will be the procedure; if this be true, it will behoove us to render our diagnoses of cholelithiasis earlier in the course of the disease than has been our wont to do.

It cannot be doubted that the ordinarily conceived picture of gall-stone disease is that of colic, jaundice, chalk-colored stools and the passage of gall-stones. That these are the symptoms which ordinarily occur only late in the course of the disease can hardly be denied, and that these are the symptoms for which we usually wait before we condescend to make, or even admit a diagnosis of gall-stones, is admitted by most.

We know of no disease, surgical in nature, whose effects are as serious as those of cholelithiasis to the tissues in and about the epigastric and right hypochondriac regions.

The following list of pathological conditions is well recognized as being directly due to the influence of gall-stones which have been permitted for too long a time to remain within the human body: cirrhosis of the liver, abscess of the liver, empyema of the gall-bladder, localized peritoneal abscess, abscess of the abdominal wall, fistula, at the umbilicus or elsewhere, cancer of the gall-bladder or ducts, subphrenic abscess, empyema of the pleura, chronic interstitial pancreatitis, suppurative pancreatitis, right basal pneumonia, right sided pyelitis due to rupture into the pelvis of the kidney, septicæmia or pyæmia, stricture of the bile passages, dilatation of the stomach, local or general peritonitis, ileus due to atony of bowel, intestinal obstructions due to paralysis, volvulus, stricture or impaction, hemorrhages resulting from long continued jaundice, infective and suppurative cholangitis, gangrene of the gall-bladder, phlegmonous cholecystitis, perforative peritonitis, extravasation of bile, inflammatory adhesions of all sorts and de-



scriptions, and finally chronic invalidism and inability to perform the duties incident to business and social life.

With such a list of possible complications as the above, are we not constrained to render our diagnosis as early a date as possible?

It is true, there are cases of cholelithiasis which exist for years without producing any symptoms whatsoever—this is abundantly proven by frequent autopsies upon persons dying from other diseases and in whom all evidence of gall-stones during life was wanting.

Such cases, however, are without the domain of treatment by both physician and surgeon, for, lacking in symptoms, they present themselves to neither.

What we do most earnestly beseech, however, is the early recognition of those cases which come WITH symptoms.

Remember that colics, jaundice, chalk stools and the passage of gall-stones are *not* early symptoms of cholelithiasis, but that they come, as a rule, LATE in the course of the disease, and are to be regarded rather in the light of RESULTS, than symptoms.

What indications, then, have we in the early months of gall-stone disease?

First and foremost, we will have what is ordinarily termed "indigestion"—nearly every case coming for operation brings a long and varied anterior history of indigestion—indigestion not only as complained of by the patient, but as diagnosed by the physician. Moynihan, in his recent and most excellent work upon this subject, says that a most cursory examination into the history of a long series of cases treated by operation show that in nearly *all* the earliest symptom was indigestion. He says that more than one-half of all his cases have never had an attack of biliary colic; that more than one-half have never had jaundice, and that only a few have ever passed any gall-stones. Ochsner puts digestive disturbances foremost in his list of early gall-stone symptoms. Kehr reports that jaundice was wanting in eighty per cent. of his cystic and cystic-duct cases. These observations are borne out by Mayo,

Robson, Murphy, Cushing, and a host of able observers.

Oft repeated attacks of indigestion incurable under the (however praiseworthy) treatment by diet and digestants, *and which are relievable only upon complete emptying of the stomach*, are a most suggestive symptom of gall-stones. The fact that such indigestion is produced, regardless of the quantity or quality of food ingested and that it is relieved only upon complete emptying of the stomach are important in the extreme. In conjunction with this, let there be a slight but gradually increasing pain radiating from the epigastrium to the right on a line with the 9th or 10th rib and centering posteriorly beneath the point of the right scapula near the spinal column—let this pain be induced or increased by deep inspiration, by pressure over the gall-bladder, by an overloaded stomach or by turning about in bed, and you have a warning which only the heedless are justified in ignoring.

A point of great tenderness between the 9th costal cartilage on the right side and the umbilicus is oftentimes a most early suggestive symptom. A previous history of typhoid fever or appendicitis should not be lost sight of. Naunyn's symptom, viz., a sharp pain induced by hooking the fingers beneath the right costal arch while the patient draws a deep breath, occurs often long before either of the four cardinal symptoms above alluded to. These, together with slightly increased liver dulness, or a slight bilious tint not amounting to jaundice, afford a group of early symptoms which cannot fail to guide one aright if he be not too lethargic in his diagnostic acumen.

Nausea and vomiting as early symptoms are second in importance only to indigestion, being nature's effort to unload the stomach which offends through overdistension.

Thus, by a more or less varied arrangement of these FEW symptoms, and by that degree of watchfulness which is DUE to our patients, let us endeavor by all means to render our diagnoses of cho-

lelithiasis at the earliest possible moment, remembering that he who waits for any of the old quartet of symptoms, viz., colics, jaundice, clay-stools and passage of gall-stones, is not only recreant to the confidence which his patient trustingly bestows upon him, but is oblivious to results, appalling in the extreme, and which his patient must suffer not only *surely*, but *soon*!

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### PUERPERAL ECLAMPSIA.

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LANE MULLALY, M. D., CHARLESTON, S. C.

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At the onset I wish to depart from the usual custom of apologizing for the subject chosen to bring before you.

In fact, I have no apology to offer, because I believe the subject of puerperal eclampsia, and the remarks I have to make concerning it, well worthy your time and consideration. I wish also to say that I claim no originality for the ideas that I shall endeavor to elucidate, and beg to express my regrets that I have nothing new to advance concerning eclampsia.

Puerperal eclampsia is a complication of pregnancy that comes to all of us at one time or another, who do obstetrical work, occurring in 2 to 4 per cent. of all pregnancies. Therefore, I feel that even though I cannot produce anything new or original on the subject, you will be interested in considering again what others have already advanced, and agree with me that the last word has by no means been spoken on this subject. I have, however, a specific purpose in view which I will bring to your notice in conclusion.

Under the head of Pathological Pregnancy, we class certain disorders as the toxemias of pregnancy. These toxemias produce the most important of the diseases and complications of pregnancy.

The changes that are constantly taking place in the body are productive of a large amount of waste material, which waste material has to be eliminated by the various functioning organs in the

body, namely the liver, kidneys, lungs, intestines, skin, etc.

You will admit without proof that these waste materials uneliminated are poisonous to the body, especially if you consider results when any organ fails in its normal functioning work.

Among these toxemias we class eclampsia or puerperal convulsions, and define it as a disease occurring during the child-bearing state, and this includes pregnancy, labor and the puerperal state, characterized by tonic and clonic convulsions, with loss of consciousness and coma, and further characterized by the fact that it never occurs except during the child-bearing period.

In truth, eclampsia may be said to be the grand finale of a toxemic condition. observation has shown that it occurs more often during the period of labor; next to this in point of frequency it occurs during pregnancy, and during the puerperal state least of all.

One of the most important points I wish to call attention to in this paper, and I apprehend you have anticipated it, is the probable cause of eclampsia. This is a part of the subject which to me is most interesting, especially as the exact cause has not as yet been definitely settled upon. All are agreed that it is due to toxemia or toxines, but the nature of the toxic material is still under discussion.

So many theories have been advanced that Zweifel has tersely said "Eclampsia is a disease of theories."

Time does not admit a discussion of all the theories put forth and the majority I shall pass over with only the mere mention, taking into consideration particularly the only one that strikes me as being the most rational.

Among the many causes advanced may be mentioned:

Constriction of the blood vessels of the brain.

Cerebral anaemia.

Cerebral oedema.

Action of bacteria on the blood.

Climatic influences.

Irritation of motor nerve centers by



blood loaded with toxins, whatever the cause of the toxins.

Uremia and albuminuria, due in part to pressure on the veins.

Alteration in the functions of the liver; and finally, intoxication with products of fetal metabolism.

From what I can learn, I believe the most popular theory has been that eclampsia is due to uremia and albuminuria. I am free to admit that on account of the growing uterus producing pressure on the blood vessels, it therefore diminishes the circulation and lessens the flow of the proper amount of blood necessary for an organ to perform its proper function, and that therefore the activity of the liver, bowels, kidneys, etc., is interfered with. But I desire to assert positively that eclampsia may occur without albuminuria; that eclampsia does not depend on albuminuria; that convulsions may occur without any sign of albuminuria, and that further, albuminuria may occur without eclampsia.

This I have recently had clearly demonstrated in two cases; in one the urine had been repeatedly examined with not a trace of albumen, and yet the patient was taken with the most severe eclamptic seizures just three weeks prior to date of expected confinement; in the other case, albumen appeared at the third month of gestation, and the woman was safely delivered of a full term infant without any sign of eclampsia.

This proves to my mind that the practice among many of producing abortion when albuminuria appears, and not giving other symptoms due weight and consideration, is bad obstetrics.

To those who endeavor to claim that eclampsia is due to a toxin which has its origin in the liver, and is maternal rather than fetal, I simply call attention to the fact that eclampsia as a rule ceases when the uterus is emptied or very soon thereafter, and therefore why should this toxin cease being developed in the liver so soon as the uterus is emptied, which proves that there must be some cause originating elsewhere to produce these

changes in the functioning power of the liver.

The most plausible theory to my mind is that of intoxication due to the products of fetal metabolism.

It is clear to me that a pregnant woman is liable to eclampsia because there is necessarily greater activity in all of her organs to provide for the growing fetus, and therefore more waste material to be disposed of, and, further and more important, there is a great amount of tissue waste in the fetus that has to be eliminated through the mother, which is too much for the already overtaxed maternal organs, and hence—eclampsia.

In other words, the maternal organism is unable to take up the products of fetal changes as well as maternal excretory products, and throw them off and as a result—eclampsia.

This theory is further proved by considering the fact that the first thing we all endeavor to carry out when called to a case of eclampsia is to empty the uterus, first of course taking some means to control the convulsions until this procedure can be carried out.

Clinical experience has taught all of us that so soon as the uterus is emptied, the convulsions usually cease, and furthermore, it has been observed that when eclampsia is threatened, and the fetus dies in utero, the symptoms disappear and eclampsia is aborted.

Again, another strong argument in favor of this theory was the observation of Winckel, and his observation has been verified by others, namely, that in multiple pregnancies there is a greater tendency to eclampsia, due to the fact no doubt that fetal metabolism is increased.

Again, it is a fact that eclampsia is more liable to occur as gestation approaches term, due again to fetal metabolism being greater on account of the growth of the fetus. Again, it is noted that maternal mortality is far less when eclampsia occurs after the birth of the child than before, showing that the cause of the toxins having been removed, nature is able to right herself, or in other

words, it is easy to put out the fire when you cease to pour on oil.

It seems to me the clinical evidence points to the fact that eclampsia is the result of a general toxemia; that this toxemia is a result of fetal metabolism, and not due to renal insufficiency or alteration in the function of the liver, the two most popular theories.

To further substantiate this theory, let us turn for a moment to the pathology of eclampsia. While this is as yet somewhat obscure, yet all are agreed that the principal lesions are found in all the organs of elimination, liver, lungs, kidneys, etc., and the lesions found show a degeneration of the various organs as would be produced by the slow instillation of toxins in the blood and thereby acting on these organs. Furthermore, Bell reports the case of a woman dying from eclampsia in which the liver showed signs of acute yellow atrophy, the kidneys being but slightly affected. That the blood was loaded with toxins he proved by injecting guinea pigs with this blood serum, and they died within 24 hours.

At the same time he injected blood from cases of nephritis and uremia which had no effect on the guinea pigs whatsoever.

As in all cases of toxemia, eclampsia is usually preceded by prodromal symptoms with which you should be entirely familiar, and thus in the majority of cases be able to ward off impending danger.

It is not my purpose to describe these, but merely to call the more common ones to your attention, which are: headache, with dimness of vision or flashes of light; oedema; vomiting; epigastric pain; mental changes, and changes in the urine.

The most important one of these is epigastric pain, though it is not as frequent a symptom as, for instance, headache, but the appearance of severe epigastric pain is decidedly a red flag that denotes a danger signal, since it is usually followed in a few hours by convulsions.

In regard to the treatment, granting that it is a toxemia due to fetal metabolism,

which is certainly a most plausible theory, you must see how important is preventive treatment, which can be summed up in a few words:

Diet, denying all nitrogenous food.

Secure elimination of the toxins by diuresis, cathorsis, diaphoresis and increasing the action of the liver and lungs, and finally, if necessary, empty the uterus.

Should the attack be on when you are called, the first indication is to endeavor to control the convulsion, and at the same time proceed at once to empty the uterus. When this has been accomplished, elimination of the toxins should be secured in the manner already mentioned.

And now, in conclusion, let me call to your attention the specific purpose I had in view in bringing up the subject of puerperal eclampsia, viz., that we are too prone to neglect women during the period of gestation.

I have endeavored to prove from the observations of various authorities that eclampsia was due to fetal metabolism producing a toxine which if recognized early renders eclampsia an almost preventable disease.

Usually a patient comes to us and says she has missed one or two menstrual periods, and asks that we be ready to confine her at the end of nine months. We accept the case, calculate for her the probably date of confinement, write it down in our book of obstetrical engagements, and too often there the case rests until she sends for us in the pains of labor or perhaps a convulsion.

This is wrong, and I wish to make a plea right here for more care and attention to pregnant women during gestation by those who attempt to do obstetrical work.

She should be seen at least once a month during the first months of pregnancy, and as term approaches at least twice a month, and by careful examination and observation, we should be able to recognize those conditions and signs which are indicative of the absorption in the blood of toxic material, and thus be-



ing forewarned, take suitable measures to ward off dire results. As Edgar has forcibly expressed it:

"When obstetricians shall accustom themselves to watch their cases of pregnancy not only for the physical signs of pronounced renal inadequacy as an index of an approaching attack, but also for the general symptoms of the overcharging of the blood with toxic material, as headache, high arterial tension, gastric disturbances, physical and mental lassitude, and further failure of the bowels, liver, skin and lungs to properly perform their functions, and intelligently treat the same, then and then only, shall they have done their whole duty by their patient, and done all in their power to correct the pre-eclamptic condition, and avert an impending eclampsia.

#### THE USE OF ALCOHOL IN MEDICINE.\*

I. P. MELLARD, M. D., ST. GEORGE, S. C.

The question as to the true place of alcohol in medicine is always a deeply interesting one, and has engaged the earnest attention and best efforts of some of the ablest minds in the profession. It is still unsettled and the last word is still unspoken. One, while according it a useful narcotic action, would deny it any power as a cardiac stimulant. Another would characterize it as a transient, highly diffusible stimulant, and the best means at our command of stimulating the heart. Some consider it of the utmost value in septicæmic conditions, while others hold that to give it in such cases is adding fuel to the fire. Others, again, have refused to use it in any cases. The pendulum has evidently swung too far in the free use of the drug, and there is, at the present time, a manifest tendency to circumscribe its use. Musser says he uses much less now than formerly, and especially in the acute infections, and gives as the great indications for its use in these affections, the "intoxications arising from septicæmic conditions and as

narcotic." If "chemical experience is the final proof of the value" of any drug, each observer has it in his power to formulate his own conclusions; and, judging by his own experience and observation, and by the experience of others, the writer considers it a valuable stimulant, and so uses it; nor does he believe its place can be filled by any other drug, and while beneficial in appropriate cases, like other valuable drugs, it is a poison, and should be prescribed with care, due regard being had to the danger of begetting the alcohol habit. Its abuse constitutes no rational argument against its use, but emphasizes the necessity of care on the part of the practitioner in prescribing it. In the writer's opinion, Osborn has formulated succinctly the legitimate therapeutic uses of alcohol, as follows: 1st, local; 2nd, to stimulate; the heart; 3rd, as a food; 4th, to increase the appetite and aid the digestion; 5th, to relieve acute internal congestions; 6th, to dilate and relax the peripheral circulation; 7th, to produce sleep; 8th, to combat poisons in the system. As to each count, doubtless all of us have had more or less experience, and are prepared to testify to its usefulness. To speak of one item only, viz., to increase appetite and aid digestion the writer vividly remembers, if you will pardon a personal allusion, the brilliant results following the use of brandy when he suffered almost total loss of digestive power, the result of a rather prolonged attack of measles. As to the use of alcohol in health, I presume all of us are prepared to subscribe to the saying of Meltzer, "Alcohol in health is often a curse; alcohol in disease is mostly a blessing."

#### REPORT OF CASES.

E. L. PATTERSON, M. D., BARNWELL, S. C.

##### I.

Laparotomy for Lacerated Wounds of Peritoneal Cavity.

Called seven miles in the country to M. C. White, male, age eleven, slender and anaemic in appearance. Found ugly lac-

\*Read before the Dorchester Co. Medical Society, July 3, 1905.

erated wound, two and one-half inches to the right of the median line, and just under the border of rib, through which protruded a portion of the transverse colon. There were two other wounds which did not enter the peritoneal cavity, though there was considerable laceration of the abdominal muscles.

History of accident as follows:—While at play, a heavy beam, through which a piece of iron tubing was driven measuring four and one-half inches in circumference and projecting eighteen inches, fell and inflicted the injuries described.

A median incision was made and the omentum and peritoneum were found to be slightly lacerated beyond the point of the external injury for about four and one-half inches, at which point the iron tubing penetrated the peritoneum and abdominal muscles, but did not penetrate the skin. The wounds were thoroughly cleansed, and the abdominal cavity flushed with normal sterilized salt solution and closed in the usual way.

A few points of interest are presented in this case. It is remarkable how such a large piece of iron with such irregular and cutting surfaces could pass through the abdominal cavity without inflicting fatal injuries. The wounds were made by a rusty, dirty iron and there was grit and dirt in abundance. The operation was performed in a country home without the assistance of any one except two members of the family, whose only aid was to hold two dim lamps, without chimneys. While the operator was as careful and as painstaking as circumstances would permit, still infection was anticipated and under surrounding conditions seemed inevitable. However, the patient made an uneventful recovery. No internal medicines were used, except small doses of salts to keep the bowels lax, no opiate being required.

## II.

### Operation for Right Inguinal Hernia.

Called nine miles in the country to see T. H., age 25 years, colored, male. Examination revealed right inguinal incar-

cerated hernia. Every method at reduction was resorted to, but no avail, the incarceration had existed for 15 hours or more, and no time was to be lost. The seriousness of the situation was made known to the patient and his family, all of whom consented to an immediate operation. Having no trained assistance except an old negro, who was a hog spayer, and who assured me that he could render valuable aid, I proceeded to clean the field of operation as best I could in a dirty negro cabin. Chloroform was given and operation performed, and recovery resulted. No remedies were employed internally, except a laxative as occasion required. Salt rectal enemas were given in both of these cases, one daily for several days.

I am almost as strong a believer in this practice as was the good doctor who gave an enema for all ills to which human flesh is heir. Two patients in his office were patiently waiting, one on an errand, and the other with a fish bone in her throat. The doctor rushed in, and the patient who was there to deliver a message arose and stumbled. Before she could recover the good doctor had administered an enema; as the surprised lady ran down the street, the patient with the bone in her throat explained to the doctor that he had made a mistake,—that she was the patient, but in laughing at the performance the bone came out; the doctor replied that, "It cures, I don't care a darn who you work it on."

### DISCUSSION.

DR. MONSEN:—I only wish to say it is gratifying to me to see that someone in country practice does not feel backward in reporting these small cases, as we term them according to the views held by our city brethren. I think we ought to encourage country practitioners in reporting cases in this manner, as to what they have done and necessarily have to do. There is work done by one or two men that if done in the city would have long and loud praises. Therefore, I hope it will be the sentiment of this Association that the country practitioners be encouraged. The city practitioners will take advantage of the situation at all times, but the country practitioner should be encouraged to report such cases to the Association.

DR. M. SIMONS:—I agree with Dr. Monsen in what he says of the work of the country practitioner, and I go a little further and say without hesitation that I do not think there is a cross-roads



in this State where we cannot find men competent to do almost any operation in surgery as well as anybody else. Medical education is so well advanced now, and so instilled among the members of the profession in this State, that it is a common thing for men to go every year and get the advantage of work in New York, Baltimore, or anywhere else, and come back able to do the work just as well as anybody else. The only advantage the city man has over the country practitioner is that he has a good operating room, always in a good state of sterilization and well lit up, and the advantage of nurses who have everything ready for him when he is ready to operate. We have men, not only in this State, but in all the States, prepared to do any operation that a surgeon can do; some may not have the experience of others, but they have all the sources of information, and the preparation to enable them to do what anyone else can. I agree with Dr. Monsen.

DR. W. P. PORCHER:—Not only are they competent to do the work, but they do it, and without the paraphernalia the city physicians have. The only exception I would make is that they have driven the city physicians into taking up specialties to keep even with the country doctor. Of course, when a man gets, say, a pin on the vocal chords, it is impossible to get it out without a delicate set of instruments such as a man could not possibly be expected to supply himself with unless he was a specialist. It would take a Croesus to provide himself with all the instruments that specialists have to have. Not only will the country practitioners do what the city men do, but they have driven them into specialties to try to keep ahead of them.

DR. F. J. CARROLL:—One advantage the city physicians seem to have over the country practitioners on which I wish to congratulate them, and that is their ability in some cases to get patients to cough up foreign bodies. I think the city specialist is more successful in making patients "cough up" than the country doctor is.

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#### PLEURISY. SERO-FIBRINOUS.\*

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A. R. FIKE, M. D., SPARTANBURG, S. C.

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By the general term pleurisy we mean a fibrinous inflammation of the whole or a part of the pleural membrane, which may be acute, subacute, or chronic; and characterized by the formation in the pleural cavity of a fibrinous, sero-fibrinous, or purulent exudation.

From a clinical point of view the disease is classified into the fibrinous, sero-fibrinous, and purulent forms of pleurisy. For the subject of this paper I

have chosen the second in the above classification: Pleurisy with effusion.

Pleurisy occurs more frequent between the ages of 20 and 40. Males are oftener affected than females. Those who are in feeble health are more susceptible than those whose health is vigorous. Among the idiopathic causes of pleuritis may be cold and exposure, but more especially injuries to the chest wall. Such injuries may not necessarily be penetrating.

As a secondary affection pleuritis occurs during an attack of some general systemic or infectious disease, chief among which is tuberculosis. A great many authors claim that three-fourths of the cases of sero-fibrinous pleurisy are induced by tuberculous infection of the pleura. Pleurisy may be one of the earliest phenomena of pulmonary tuberculosis, but more frequently it complicates the later stages.

Pleurisy is not always accompanied by symptoms. The onset may be so insidious, or so entirely devoid of symptoms as to be overlooked by the patient, and when examined by a physician is surprised on being informed that his chest contains a considerable amount of fluid. His chief complaint is cough or shortness of breath, especially on exertion, or, possibly some pain in the side. There is more or less depression of the general health; appetite is impaired, strength is diminished, and there is usually a considerable degree of pallor.

Pain may be one of the earliest symptoms, appearing over the lower and anterior surfaces of the affected side. The pain varies greatly in intensity, diminishing or disappearing as the fluid accumulates, but reappears if the effusion is absorbed or removed, allowing the visceral walls to again come together.

Cough is occasionally a prominent symptom, but may be absent. In character the cough is dry, suppressed with but slight or no expectoration.

The breathing is quick and shallow. Where the function of the lungs are impaired by a very copious effusion, dyspnoea may become intense.

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\*Read before the Spartanburg Co. Medical Society, June 30, 1905.

The elevation of temperature usually comes on gradually and very seldom reaches a high point.

*Phys. Signs:* The affected side will appear fuller because the intercostal spaces do not show, having a rounded, smooth appearance; the angles of the chest are less acute than normal. The apex beat of the heart is often displaced.

Percussion reveals an area of absolute dullness when the fluid has accumulated. If the pleural cavity is not over full of fluid, a change in the position of the body will also cause a change in the area of dullness. Unless the lungs are solidified, the respiratory sounds are not transmitted through pleural effusions.

The physical signs of an effusion into the pleural cavity are so definite, that it can be diagnosed directly by the coincident (1) want of expansion on the affected side; (2) prominence of the intercostal spaces; (3) percussion flatness; (4) absence of vocal fremitus, (5) and almost always absence of respiratory sounds.

After the existence of an effusion has been determined, it is necessary to ascertain whether the fluid is serous or purulent. We can only decide this positively after an experimental aspiration with a hypodermic or aspirating needle.

*Treatment.*—Our first attention of course is directed to the alleviation of pain, if it be present. I have found small fly blisters, repeated every two or three days, changing the area of application each time are very beneficial. Or the affected side may be "strapped." Relief is often afforded by applying long strips of adhesive plaster to the affected side, preventing or limiting motion of same. Beyond this little is accomplished by local means. If pain is very severe, opiates must be used. Here heroin seems to serve a double purpose, relieving both the cough and the pain.

There are a number of drugs commonly employed to promote re-absorption of an exudate, but with doubtful utility. The salines, diuretics, and diaphoretics have each their advocates. The chief among them is iodine or the iodides, either ap-

plied externally to the chest wall or administered internally. I have found the iodides of little benefit, usually causing disturbance of digestion. A saline cathartic on waking, followed by a diuretic, such as the acetate of potash or ammonia, perhaps combined with digitalis, would no doubt give better results.

Aspiration affords a means of withdrawing the fluid surely and promptly, and if properly done is without danger. If the amount of fluid is large, it should be preferred to any of the methods that are employed to promote absorption.

*When to aspirate.*—(1) First, if there is a large amount of fluid. (2) Second, if the fluid remain without change for ten days or two weeks. And (3) there are no contra-indications to aspiratings.

In preparing to aspirate the chest, first be sure that your instrument is in working order, and that your needle is sterile. The patient may sit, which is preferable, or recline while the fluid is being withdrawn. Select a point in the lower axillary space, usually in the sixth interspace. The skin should be cleansed with an antiseptic solution. A few drops of a solution of cocaine should be introduced beneath the skin. Here make your puncture, guiding the depth with your finger on the needle. A sense of diminished resistance usually tells the operator that the needle has entered fluid.

The patient should be instructed to inform you upon feeling the slightest discomfort, "whether it be pain or a sense of constriction or desire to cough." Noticing any discomfort whatever, the aspiration should be suspended at once and the needle withdrawn. This is the best guide as to the amount of fluid to withdraw at one time. However, a large amount should not be withdrawn at one sitting, (not exceeding oz. xxx), as the operation can be repeated as often as necessary. It is not our object to try to remove all of the fluid with the aspirator, because removing a portion seems to arouse the powers of nature to take up the work of absorption, even after the first operation. If the fluid remains stationary for several



days, say a week, the operation should be repeated. After the needle is withdrawn, the wound should be covered with a piece of adhesive plaster. To avoid danger in this operation, it is necessary that you observe the principles of asepsis; the slow removal of a limited amount of fluid; and suspending the operation upon the notice of any distress on the part of the patient.

Where the process of absorption is very much delayed or slow and tedious, and you have added to your diuretics, supportive and tonic treatment with but little benefit, then I would recommend a change of climate.

Even with the disappearance of the effusion and its effects, the task of the physician is not yet accomplished. The patient should be regarded as particularly liable to the development of tuberculosis, and should be kept under close observation. Any depreciation of general health, particularly of apical catarrh, should be watched for, and if it develops the patient should be immediately placed under strict hygienic surroundings with increased alimentation and out-of-door life.

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**EXTRACT FROM THE MINUTES OF  
THE HOUSE OF DELEGATES,  
AMERICAN MEDICAL  
ASSOCIATION.**

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**Missouri Resolutions on Secret Nostrums.**

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Dr. Dorsett, Missouri, under "New Business," presented a resolution from the Missouri State Medical Association as follows:

*Gentlemen:*—At the last meeting of the Missouri State Medical Association, held at Excelsior Springs, Mo., April 16 to 18, this year, the following resolution was passed:

*Resolved,* That the three delegates of the Missouri State Medical Association to the American Medical Association be appointed a committee to prepare a resolution embodying the sentiments of a paper read by Dr. William G. Moore, of St. Louis, entitled "The Present Status of Therapeutics."

This paper dealt with the subject as its title

signifies, and drew attention to the fact that many of the remedies now used in the daily practice of the vast majority of the practitioners of this country, were of the so-called proprietary kind, the exact composition of which is unknown, save to the manufacturer of the remedy; and that the practitioner thus using such a remedy lowers the dignity of his profession.

Again, the responsibility of the profession is shown in the license allowed medical journals, which are absolutely their creatures and should be under their control, to advertise these remedies, not only in their advertising pages; but also by reading notices scattered throughout their columns.

Therefore, the delegates of the Missouri State Medical Association respectfully present the following:

*WHEREAS,* The majority of the so-called proprietary remedies are secret nostrums whose formulæ are unknown to the medical profession; and

*WHEREAS,* The use of such remedies stifles investigation of rational therapeutics and lowers the standard of our practice to mere empiricism; and

*WHEREAS,* The medical journals, the creatures of our profession, are filled with advertisements of these nostrums enlisting the attention of the unwary practitioner and resulting in enriching the manufacturer and defrauding the unsuspecting patient; therefore be it

*Resolved,* That it is the sense of this body that the use of these remedies by members of the American Medical Association is reprehensible and that these advertisements should not appear in reputable medical journals.

WALTER B. DORSETT,  
A. R. KIEFFER.

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**Resolutions of Section on Practice Endorsing  
Council on Pharmacy.**

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Dr. Wells, Illinois, presented resolutions from the Section on Practice of Medicine, which were referred to the Committee on Reports on Officers.

*WHEREAS,* the Medical profession of the United States has too long neglected to recognize the harm to the public, to the members of the profession, and to scientific medicine from the nostrum evil; and

*WHEREAS,* The Board of Trustees of the Association has created a body known as the Council on Pharmacy and Chemistry, to investigate and pass on the various non-official medicinal preparations placed on the market; therefore be it

*Resolved;* That we, individually and collectively, heartily endorse the action of the Board of Trustees, and earnestly urge every physician to give this effort of reform his hearty support.

*Resolved,* That the Board of Trustees be requested to effect the removal of the remaining nostrum advertisements from the pages of THE JOURNAL of the American Medical Association.

*Resolved*, That the representatives of this Section to the House of Delegates be instructed to present these preambles and resolutions to the House of Delegates, with the recommendation of this Section for their endorsement, and that a copy of the same be sent to the president and secretary of each constituent society of the American Medical Association.

#### Asks that Formulae Appear in Every Ad.

Dr. Jones, California, moved that the House of Delegates instruct the Board of Trustees to abide by the rule which it adopted in 1895, and in 1900, to the effect that no advertisement of a remedy shall be printed in the pages of *THE JOURNAL* unless the formula, giving the quantities of the active ingredients of each dose, be stated, with each insertion of that advertisement. Seconded by Dr. Sanders.

On motion of Dr. Harris, New York, this resolution was referred to the Committee on Reports of Officers.

#### Extract from the Report of the Committee on Reports of Officers.

#### Missouri, Practice of Medicine and Jones' Resolutions Favored.

6. We indorse the underlying sentiments of the preamble and resolutions presented by the committee of the State Medical Society of Missouri, of those presented by the Section on Practice of Medicine, and of the resolution presented by Dr. Jones, of California.

#### Declared Reprehensible to Use Nostrums.

7. We recommend the adoption of the following motions:

*Resolved*, That it is reprehensible for the members of this organization to prescribe or use nostrums, and that we request the Board of Trustees not to advertise any nostrum in the columns of *THE JOURNAL*.

#### Journal Ads. Should Contain Formulas.

*Resolved*, That we request the Board of Trustees hereafter to insert in *THE JOURNAL* with each advertisement the formulas of remedies which

may have been favorably passed on by the Council of Pharmacy and Chemistry for advertisement.

On motion, these recommendations of the committee were concurred in.

—*Journal A. M. A.*

#### DR. HERMANN NOTHNAGEL.

In the death of Dr. Hermann Nothnagel, of Vienna, which occurred on July 4th, one of the few remaining pathfinders of modern medicine has passed into the great beyond. Bilstroth, Nothnagel, Kraft-Ebbing and Politzer were the four great beacon lights of the Vienna school from 1875, till death calmly claimed them one by one, reducing the candle power on this well lit coast by quarters, till now but one quarter remains. This remaining quarter is Politzer, whose bag made him famous throughout the medical world.

Since the days of this great quartet, Vienna has produced many able physicians and surgeons, but none stand today, as they once stood, pre-eminent in their respective branches throughout the medical world. There is scarcely a book of any consequence in medicine published in the last two decades that fails to refer to the great Nothnagel as an authority on some special sign, or pathological or physiological point. What a fame!

Nothnagel has probably consulted in every capital in Europe, and his dictum on internal medicine was final, the supreme court of diagnosis throughout Europe.

His wonderful series of monographs have been translated into many languages, and in America have recently been compiled and edited into what is probably the finest encyclopedia of medicine up to the present writing.

Like the rest of this great quartet, Nothnagel had a fine address, a fine personality, and physically and mentally was a giant. When Nothnagel entered the amphitheater, a great applause was rapidly succeeded by a profound silence, akin almost to awe at his grand presence. A hush fell over the multitude assembled to hear the words of wisdom they knew were forthcoming.

May his rest be as perfect as his life work was profitable to mankind.



**DIRECTORY OF COUNTY SOCIETIES.**

- Abbeville, Sec., Dr. C. C. Gambrell, Abbeville, S. C.
- Aiken, Sec. Dr. W. C. R. Turnbull, Aiken, S. C.
- Anderson, Sec., Dr. J. B. Townsend, Anderson, S. C.
- Bamberg, Sec., Dr. J. J. Cleckley, Bamberg, S. C.
- Barnwell, Sec., Dr. L. F. Bonner, Blackville, S. C.
- Beaufort, Sec., Dr. M. G. Elliott, Beaufort, S. C.
- Berkeley,—Not organized.
- Charleston, Sec., Dr. J. C. Mitchell, Charleston, S. C.
- Cherokee, Sec., Dr. B. L. Allen, Gaffney, S. C.
- Chester, Sec., Dr. W. B. Cox, Chester, S. C.
- Chesterfield,—Not organized.
- Clarendon, Sec., Dr. L. C. Stukes, Summerton, S. C.
- Colleton, Sec., Dr. Chas Es Dorn, Walterboro, S. C.
- Darlington, Sec., Dr. J. C. Lawson, Darlington, S. C.
- Dorchester, Sec., Dr. J. B. Johnston, St. George's, S. C.
- Edgefield, Sec., Dr. J. G. Edwards, Meeting St., S. C.
- Fairfield, Sec., Dr. R. B. Hannahan, Winnsboro, S. C.
- Florence, Sec., Dr. F. H. McLeod, Florence, S. C.
- Georgetown, Sec., Dr. Olin Sawyer, Georgetown, S. C.
- Greenwood, Sec., Dr. R. B. Epting, Greenwood, S. C.
- Greenville, Sec., Dr. J. R. Ware, Greenville, S. C.
- Hampton, Sec., Dr. C. A. Rush, Hampton, S. C.
- Horry, Sec., Dr. J. A. Norton, Conway, S. C.
- Kershaw, Sec., Dr. S. C. Zemp, Camden, S. C.
- Lancaster, Sec., Dr. J. E. Poore, Lancaster, S. C.
- Laurens, Sec., Dr. R. E. Hughes, Laurens, S. C.
- Lexington, Sec., Dr. J. J. Wingard, Lexington, S. C.
- Marion, Sec., Dr. E. Marvin Dibble, Marion, S. C.
- Lee, Sec., Dr. L. H. Jennings, Bishopville, S. C.
- Marlboro, Sec., Dr. J. H. Reese, Tatum, S. C.
- Newberry, Sec., Dr. J. G. McMaster, Newberry, S. C.
- Orangeburg,—Not organized.
- Oconee, Sec., Dr. D. L. Smith, Newry, S. C.
- Pickens, Sec., Dr. H. E. Russell, Easley, S. C.
- Richland, Sec., Dr. Mary R. Baker, Columbia, S. C. (Columbia County Medical Co.)
- Saluda, Sec., Dr. J. D. Waters, Coleman, S. C.
- Spartanburg, Sec., Dr. O. W. Leonard, Spartanburg, S. C.
- Sumter, Sec., Dr. Walter Cheyne, Sumter, S. C.
- Union, Sec., Dr. Theo. Maddox, Union, S. C.
- Williamsburg,—Not organized.
- York, Sec., Dr. J. R. Miller, Rock Hill, S. C.

## COUNTY NEWS.

**CHARLESTON:** At a meeting of the Medical Society of South Carolina, of Charleston County, held on August 1st, the following physicians were elected to serve as commissioners of the new Roper Hospital: Dr. T. G. Simons, Dr. J. S. Buist, Dr. R. S. Cathcart, Dr. J. LaR. Wilson, and Dr. A. R. Taft.

The work on the new hospital is progressing rapidly; no doubt is entertained that it will be ready for occupancy by the specified time.

**MARION:** The Marion County Medical Society has undertaken to work for the establishment of a County Hospital, to be located at Latta, Mullins, Dillon, and Marion, respectively. Papers are read and discussed at each meeting. The society has already accomplished much in bringing the physicians of the county into closer touch with each other and establishing good feeling. The next meeting will be held at Latta in September.

**PICKENS:** The meeting of the Pickens County Medical Society was held in the Masonic Hall, at Easley, S. C., Aug. 9, 1905, at 2:30 o'clock.

Dr. R. J. Gilliland, President, called the Society to order. Not all the members were present, but a most interesting meeting was enjoyed.

Dr. James L. Bolt, of Pickens, S. C., presented a practical and timely paper on puerperal eclampsia, in which he set forth his experience and methods on this most important subject in a plain and comprehensive manner that pleased and edified every one.

The secretary, Dr. H. E. Russell makes the gratifying report that from a condition of lethargy, disorganization, and absolute indifference to professional progress, the new plan of organization, and the earnest endeavors of the State Medical Association have inspired the medical fraternity of the county with renewed interest, and the Society in Pickens bids fair to become a fertile source, not only of social interest, but of marked professional and scientific advancement.

The entire county will be inestimably benefited by the presence of a progressive and enlightened medical profession.

The meeting adjourned until Sept. 13th.

## CORRESPONDENCE.

### A Letter from the Treasurer.

*Editors Journal of the South Carolina Medical Association:*

GENTLEMEN:—

The Treasurer would respectfully request to be allowed the advantage of your columns to place be-

fore the members of our Association some facts in regard to the financial affairs of our body.

As we are now working, under our new Constitution, all dues will be paid by the Secretaries of the various County Societies to the Secretary of our State Association, who in turn remits them to the Treasurer. I would ask each member, and especially the Secretaries of the County Societies, to very carefully read Sections 13 and 14, of Chapter IX, of our By-Laws.

As all of the County Societies were re-organized at the Greenville meeting, the assessments paid by the various County Societies at and since this meeting, will cover those due for year, April, 1905, to April, 1906. This is done to simplify matters, as some of the County Societies were chartered before this meeting, and I have found it impossible to obtain an accurate list of these societies. After carefully considering this matter, it has been thought best to let the dues already collected from the County Societies cover their assessments from April, 1905, to April, 1906. This course is a little different from what we had intended to pursue, but the change is essentially necessary. Such being the case, I will have to collect from the individual members up to April, 1905, in order to close out all individual accounts. I would, therefore, ask each member to promptly respond to the notices that will be shortly mailed them, as I feel that they are as much interested as I am to get these matters straight.

Now, in conclusion, a word in regard to the method of forwarding assessments due by the County Societies. The total list of members should be made up and the amount forwarded to the Secretary of the State Association before April 1st, preceding Annual Meeting. Every member should be accounted for then. If the member has not paid the County Society, it is a matter between them, the State body having nothing to do with it. He should be held up, and if the rules have not been complied with, dropped by the County Society. This point is important,



as some of the Secretaries of our County Societies are sending in their assessments irregularly. For instance, the Secretary of a County Society of forty-one members, will send \$87.00 for twenty-nine members; then in three or four weeks' time \$3.00 more for another member; then some time after this another \$3.00, and so on, until the account is finally paid. This method will mix us all up very badly, and it is as well to correct it in the beginning. Any one will understand that the Treasurer has only to receive the money as turned over to him by the Secretary. Now, how in the world can the Treasurer correctly keep his accounts if he does not know the total amounts to be charged against each Society? There will, however, be no difficulty if our Constitution is closely followed, and I would ask each Secretary to carefully bear in mind these facts, and particularly to make one, and only one remittance, letting this cover the full amount of assessments at the per capita rate of \$3.00 per member.

Respectfully,  
C. P. AIMAR, M. D.,  
Treasurer.

Approved, July 22, 1905.

S. W. PRYOR, Acting President.

#### A CORRECTION.

ELLOREE, July 25th, 1905.

Ed. *Journal of the S. C. Med. Ass'n.*:

DEAR SIR:—

In the paper written by myself and printed on page 48 of your *Journal*, under the title, "Fractures of Every Limb," the word "March" in the third line of paragraph two should be February.

Please state in your next issue that the word "March" in second paragraph should be read *February*.

Respectfully,  
M. J. D. DANTZLER, M. D.

## NOTES AND REVIEWS.

### SURGERY.

A. J. BUIST, M. D.

#### Successful Ligature of the Innominate Artery.

William Sheen reports in the *Annals of Surgery* the eighth successful ligature of the innominate artery. The operation was performed for the cure of an aneurism of the second and third parts of the right subclavian artery. Although the artery was successfully tied, pulsation returned in the tumor and a second operation was attempted some weeks later. Because of hemorrhage, this operation was a failure, but at a subsequent date a third operation was performed in which the subclavian artery was ligated, with the result that the patient made an uneventful recovery.

From a study of his own and thirty-five other cases, Sheen deduces the following conclusions:

1. That in properly selected cases ligature of the innominate artery is a reasonably safe and undoubtedly useful operation.
2. That suitable cases are those in which the aneurism is of a circumscribed, globular character, and the general condition of the patient is good. That unsuitable cases are those in which the aneurism is fusiform, and in which there are marked signs of arteriosclerosis with accompanying visceral disease.
3. That the maintenance of asepsis is the main factor in obtaining a successful result.
4. That the incision should be central, with horizontal and vertical division of the manubrium, if necessary.
5. That the carotid should be tied as well as the innominate.
6. That silk is the best ligature material.
7. That some amount of injury to the inner coats is probably necessary to insure occlusion, but that with aseptic conditions such injury does not matter.
8. That two ligatures should if possible be placed round the vessel, the first turn of the proximal ligature being held tight, so as to keep back the blood while the distal ligature is completely tied.
9. That the use of a drainage tube is inadvisable.
10. That as next to sepsis some cerebral lesion has been the most frequent cause of death after operation, it would be well for future operators to consider the advisability of tying the carotid about a fortnight before the innominate.

#### Appendicostomy.

Much attention is at present being paid to the treatment of diseases of the caecum and colon by irrigation through the appendix, which is brought out of and attached to the abdominal wall. The advantages of this method of irrigation over that by means of the rectal tube are that the caecum and colon can be thoroughly irrigated; that medication can be applied at the point in the colon where post-mortem examinations show the lesions are most prominent; that

it is a painless procedure, and that there is no fear of the development of a proctitis. The technique of the operation is as follows: The abdomen is opened by the inter-muscular method, and the appendix sought for and found. The meso-appendix is ligated and with it the artery of supply to the appendix. The appendix is then brought out over the skin. A suture is then passed at the lower angle of the wound through the peritoneum, the muscular wall of the caecum at its juncture with the appendix, and back through the peritoneum on the opposite side of the wound; a second suture is then passed about one-half inch above the other, through the same tissues, but on the upper side of the appendix. The abdominal wound is now closed in the usual way and a simply dry dressing applied. In thirty-six hours this may be removed when the appendix is found adherent to the wound and usually its tip gangrenous. It is now cut off one-fourth of an inch from the skin of the abdomen, a small dilating instrument inserted and this followed by the introduction of a No. 10 to 12 soft rubber catheter. The stump of the appendix is now tied about the catheter and irrigation can be begun at once. The catheter should be introduced not over four inches. When indications for irrigation have ceased, if the opening does not close spontaneously, it may be touched with the cautery or the stump of the appendix may be separated from the abdominal wall, ligated and dropped back into the abdomen.

## OBSTETRICS AND PEDIATRICS.

LANE MULLALLY, M. D.

### Puerperal Eclampsia.—Parathyroid Treatment for Eclampsia.

Prof. Vassale, of Modena, has been applying in therapeutics the extract of the parathyroid glands. He has found the active principle of the parathyroid glands remarkably efficient in the treatment of puerperal eclampsia. The relations between the thyroid gland and pregnancy have long been studied, and it proved a great disappointment when thyroid treatment failed to display appreciable efficacy in the treatment of puerperal eclampsia.

Vassale has taken up the study again, but uses the extract of the parathyroid glands alone.

At the Italian Congress of Gynecology last year, an experimental study was presented on "Thyroparathyroid Insufficiency and Eclampsia," which supplied an experimental foundation for parathyroid treatment.

Pestalozza urges its trial on a large scale in the treatment of Eclampsia.

The extract is called Parathyroidine or parathyres-antitoxine, prepared by the Institute for Sero-Therapy at Milan.—(*Journal A. M. A.*)

Edebohls (Trans-American Gynecological Society, 1904) recommends Renal Decapsulation for Puerperal Eclampsia and reports two cases as successful.

Krönig and Max Henkel both report cases successfully treated by lumbar puncture.

Wilson (Jour. Am. M. A., Oct., '04) believes Uremia and Eclampsia are the same, and produced by the same causes, though the conditions are varying.

He calls attention to the fact that they are always due to disease of kidney.

The author believes that many of the symptoms found in both diseases show signs of pressure symptoms, and can be overcome by relieving pressure on the central nervous system. He concludes as follows:

1. It is probable that there are at work in the cerebrum, as well as throughout the system of uremic subjects, at least one, and probably several toxic substances which exert their influence more or less on the cortex.

2. It is equally certain that other portions of the brain than the cortex are also acted on, as in the production of coma, etc.

3. No small part in the production of the uremic and eclamptic condition is played by intracranial pressure, due to a temporary excess of fluid, whether acting independently of, or in conjunction with, the toxic substances already mentioned.

4. Lumbar puncture will, at least temporarily, relieve certain of the symptoms most readily ascribed to localized intracranial pressure, and that in cases in which the pressure is the main factor, drainage of the spinal canal may save life. The procedure, together with free bleeding, purging and diuresis, should be added to our routine treatment of the condition.

5. Transfusion of normal salt solution by intravenous injection or hypodermoclysis, except in cases presenting anuria, or a greatly diminished urinary secretion, is contra-indicated as tending to increase the liability to saturation of the tissues.

6. The results of lumbar puncture in the three cases cited in this paper will not warrant the assumption that relief of intraspinal or intracranial pressure can, alone, be depended on to cure the uremic or eclamptic condition, provided toxic influence is the prominent one in the particular case.

### Post-partum Hemorrhage.

Dr. H. H. Loveland, Syracuse, N. Y., (Am. Med., Apr., 1905), in a most exhaustive article on "Post-partum Hemorrhage," concludes as follows:

1. Post-partum hemorrhage is one of the most serious complications found in obstetric practice.

2. It is not always preventable by careful management of the third stage of labor, as some authors seem to believe.

3. The first step in the treatment of a rapid and severe case is the insertion of a hand in the uterus, the other meanwhile manipulating the fundus through the abdominal wall.

4. Of all the intrauterine treatments except the first mentioned, hot-water douching is the most convenient, the most cleanly, and the most effective.

5. No obstetrician's outfit is complete without apparatus for the infusion of salt solution and for intra-uterine douching.

6. The benefit to be gained by packing the uterus with gauze is doubtful, the danger is evident. Later experiences, not only in post-



partum hemorrhage, but in other conditions in which uterine hemorrhage is feared, as after curetting for abortion, or miscarriage in the early months of pregnancy, have firmly convinced me that it is not wise to put anything into the uterus that is not necessary, nor to leave anything that can be avoided, even though impregnated with antiseptics.

### The Immediate Repair of Injuries of the Perineum Received in Childbirth.

(*Am. Jour of Gyn. and Pediat.*, July, 1904.)

D. E. W. Cushing insists on the immediate repair of laceration of perineum. He condemns as not only useless but injurious the custom of sewing up the external parts, and leaving the vaginal tear ununited, for here the lochial secretions are retained in contact with an open wound. Under an anaesthetic, he recommends the perineum to be repaired before the placenta comes away. (This last recommendation is questionable. There can be no advantage in the few minutes' time saved, and further, in cases of retained or attached placenta, when it may be necessary to introduce the fingers or a curette, your surgical work must be undone, otherwise you run the risk of tearing out every stitch. There are, however some excellent text books that recommend this procedure.—L. M.—)

### Treatment of Hyperemesis Gravidarum.

Uhle reports a case of uncontrollable vomiting prolonged through the third month of pregnancy, that continued for weeks after all food and medicines had been stopped.

The uterus was decidedly antiflexed. All remedies having failed abortion was decided upon, and, as a preliminary step, a colpeurynter was placed in the vagina just beyond the entrance, and partially filled; in this way the uterus was lifted from below. The result was that the vomiting ceased at once, and the patient was able to retain a little milk. At night the colpeurynter was removed, but the vomiting recurring, was replaced next morning with equally beneficial results. The pregnancy progressed to a normal termination.—*Jour. A. M. A.*

### Gastric Ulcer in Children.

Stowell, of New York, (*Medical Record*, July 8th), saw a child, age 8, apparently dying from pneumonia. There was distension of abdomen, though not marked, and epigastrium was found tender on pressure. Child had complained of pain in the stomach, had delirium shortly after being seen by the author and died.

Post-mortem examination showed two ulcers, each about  $\frac{1}{8}$  of an inch in diameter on the

posterior surface of the stomach, about two inches from the pylorus, that had perforated the walls of the stomach.

He discusses symptoms and treatment which is the same as in adults, and says that the prognosis does not depend on age.

Stowell states that 35 are all of the published cases of gastric ulcer in children.

### Treatment of Diarrhoea in Children.

Winters believes that diarrhoea is due entirely to food, and that taken in hand promptly, recovery should always take place.

He recommends removal of the cause by prompt administration of castor oil. Following this, water only is given for 24 hours, and in severe cases he withholds food for 36 to 74 hours.

After this time food modified is allowed, and full directions for modifying food are given by the author. Winters condemns barley water as a food for infants, not only in sickness, but also in health.—*Medical News*, July, 1905.

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## BACTERIOLOGY AND PATHOLOGY.

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G. F. MOOD, M. D.

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*Bacteriology of Appendicitis.*—Dr. Perrone, of Naples, (*Annales de L'Institut Pasteur*, June, 1905,) studies bacteriologically 428 diseased and 8 normal appendices.

In the 8 normal appendices, the findings were as follows (Lanz and Tarel):

Streptococcus Pyog. in 2 cases, or 25%.

Diplo. Strep. Intestinalis in 3 cases, or 37.5%.

Colon Bacillus in 8 cases, or 100%.

Proteus in 1 case, or 12.5%.

Bacillus of Malig. Oedema in 5 cases, or 62.5%.

Pseudo Tetanus Bacillus in 5 cases, or 62.5%.

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In 2 cases the Colon Bacillus was found in pure culture. In no case was the appendix sterile.

Of the 428 diseased appendices, both acute and chronic, 14 of which were studied by Dr. Perrone, findings were as follows:

Pus was sterile in 40 cases.

Colon Bacillus in pure culture in 203 cases.

Colon Bacilli associated with other organisms in 175 cases.

Drs. Lanz and Tarel conclude:

"That the normal appendix is never sterile, it harboring usually several species of organisms, the Colon Bacillus being always present.

"The diseased appendix is sterile in 10% of cases. The Microbic Flora is the same, qualitatively, as in the normal appendix. The more the appendix is diseased, the less the number of kinds of micro organisms found there.

"The normal appendix should show a microbic flora similar to that of the large intestine, and, in fact, this is the case; there is, therefore, no reason for finding it sterile. The diseased appendix, on the contrary, contains in its secretion many leucocytes, and an active phagocytosis is going on, which results in a rather large number of cases, in sterilization of the contents. When the appendix has absolutely recovered, the leucocytes disappear, and conditions are the same as in the normal appendix.

In 1898, Veillon and Züber examined 22 diseased appendices for anaerobic organisms, with positive results in 21 cases.

In one case, the *Pneumococcus* (Aerobic) was found in pure culture.

In 2 cases, Anaerobic organisms were found alone.

In 19 cases, Anaerobes were found, associated with *Streptococci* and *Colon Bacilli*.

Dr. Perrone has studied 14 cases of appendicitis, as concerns both Aerobic and Anaerobic organisms.

In 1 case—pus found sterile.

In 10 cases—*B. Coli* found.

In 10 cases—Anaerobic organisms found.

In 1 case—Anaerobic organism in pure culture.

Dr. Perrone concludes that appendicitis is undoubtedly a microbic disease. That anaerobic organisms can be found in the majority of cases, if carefully looked for, and that they are often found in greater proportion than the aerobe.

He does not consider the colon bacillus the pathogenic organism of appendicitis, but is convinced, with Metchnikoff and Veillon and Züber, of the pathogenic importance of anaerobic organisms in appendicular affections.

*Anti-Rabic Vaccination, at the Pasteur Institute during 1904.*—Jules Viola (*Annales de L'Institut Pasteur*, June, 1905.)

During 1904, 757 persons underwent treatment for the prevention of Hydrophobia at the Pasteur Institute, with a mortality of 5, or .66%. Two (2) of these, however, developed Hydrophobia in less than 15 days after treatment, and should therefore be left out; giving:

Cases treated .....	755
Deaths .....	3
Mortality .....	39%

## MISCELLANY.

### A Compliment to an American Physician.

Dr. T. D. Crothers, of Hartford, Conn., Supt. Walnut Lodge Hospital, has accepted an invitation to deliver the first oration in the Norman Keer Memorial Lectureship, at London, Eng., Oct. 10th, 1905. Dr. Keer will be remembered as an eminent London physician who made a special study of Inebriety, Alcoholism and other drug disorders. He wrote several excellent books on this subject, and was instrumental in securing the enactment of laws for the control of inebriates, and the promotion of Hospitals for their care throughout Great Britain. He founded the British Society for the study of Inebriety, in 1884, and this Society, and his friends, have organized a memorial Lectureship for yearly orations on his life and work. It is a very pleasant recognition of the progress of medical science in this country, that an American physician should be invited to deliver the first Lecture.

### THE ECONOMY OF PRESERVING THE HEALTH OF SCHOOL CHILDREN.

If a man were to deliberately gradually starve his child, there is a law which would punish him. But food starvation is not the only kind of starvation. There is air starvation, and its victims fall everywhere like autumn leaves. There is no law against the killing of children, nor against the killing of anyone by slow air starvation. We may live for forty days without food, and for five or ten days without water, but we cannot live five minutes without air. The diseases which



follow gradual air starvation are: Influenza, coughs, colds, catarrh, pneumonia, consumption and the whole list known as diseases of the respiratory tract. Air starvation also frequently has following it, mal-nutrition, headaches, neurasthenia and other ills. Air is free. We do not have to buy it at the grocery. Unlike many foods it is not colored with coal tar dyes, nor preserved with boric acid, salicylic acid, or other chemicals, nor can it be cornered by the trusts. Why, then, suffer from air starvation? Why not always keep our lungs full of pure air, and thus always have our blood thoroughly oxydized? If we will do so, the microbes of influenza, coughs, colds, catarrh, pneumonia and consumption will knock in vain for admittance. This is not a theory; it is simply a discovered fact. Even after we have acquired the worst of the above diseases, consumption, provided it is not far advanced, may be routed by continuous life in the open air. This is being done every day in certain very progressive States, and particularly in Germany, and therefore is not an experiment. —*Bulletin Indiana State Board of Health.*

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#### A FAMILY TRAGEDY.

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The following is a true tale of a recent happening in an American city. It is a good story to relate to patients and legislators in the campaign against nostrums and against adulterated foods and drugs. A respected clergyman fell ill, and the family physician was called. After examining the patient carefully, the doctor asked for a private interview with the patient's adult son.

"Harry," said the doctor, "do you know what is the matter with your father?"

"No. We sent for you to tell us that."

"Well," the physician said, "I am sorry to tell you that your father undoubtedly is suffering from chronic alcoholism."

"Chronic alcoholism! Why that's ridiculous! Father never drank a drop of liquor in his life, and we know all there is to know about his habits."

"Well, my boy, it's chronic alcoholism, nevertheless, and at this present moment your father is drunk. How has his health been recently? Has he been taking any medicine?"


"Why, for some time, six months I should say, father has often complained of feeling unusually tired. A few months ago a friend of his recommended 'Peruna' to him, assuring him that it would build him up. Since then he has taken many bottles of it, and I am quite sure that he has taken nothing else."

In this connection it might be added that a very prominent anti-saloon worker, a clergyman, lately said that in shame he was compelled to admit that he had run across indubitable proof that there are ministers of the gospel who receive pecuniary commissions from the makers of alcoholic nostrums whose wares they recommend! Than this there can be no worse form of graft. The time is here for the organized profession to join hands with all other workers and organizations, whether anti-saloon leagues, temperance unions, or courageous anti-nostrum publications, to set a definite limit to the progress of respectable and innocent intemperance.—*Journal A. M. E.*

# The Journal

OF THE

## South Carolina Medical Association



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### South Carolina Medical Association

Next Annual Meeting at Columbia, S. C., April 18th, 1906.

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For further information, apply to

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CHARLESTON, S. C., Aug. 15, 1905.

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This is to inform you that I now  
occupy my new store northwest corner of  
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complete line of drugs, Pharmaceuticals  
and Chemicals. It will be my endeavor to  
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past and ask a continuance in the future.

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W. L. SPEISSEGGER.

# THE JOURNAL

OF THE

## SOUTH CAROLINA MEDICAL ASSOCIATION.

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4 Vanderhorst Street, Charleston. S. C.

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C. P. AIMAR, Managing Editor.	

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THE JOURNAL is published monthly under the auspices of the South Carolina Medical Association. Members who do not receive their copies will please notify the Managing Editor at once. Secretaries of county societies are requested to send reports of their meetings, and items of news that may be of interest to the profession. Original articles are solicited. Articles should be type-written; and illustrations sent with articles will be printed at the expense of the writer. Reprints will be furnished at the rate of 75c. a page for a hundred pages.

All matter must be in the hands of the editor by the 10th of each month.

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### EDITORIAL COMMENT.

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#### A COMPARISON.

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It is a commonplace remark that familiarity with danger breeds within us an indifference to perilous situations. The soldier accustomed to the carnage of battle looks unconcernedly upon scenes before which another would recoil with fear; and they that go down to the sea in ships are less mindful of the perils of the deep than they to whom such experiences are new and strange. Perhaps it is the same cause which tends to make us indifferent to the dangerous presence of so common a disease as tuberculosis, while an occasional epidemic of yellow fever creates a deep and wide-spread feeling of fear, which in some localities produces a condition akin to panic. It is true that yellow fever spreads more rapid-

ly, kills more quickly, and causes more deaths in a short period of time than tuberculosis, but in our climate the epidemic dies with frost. Tuberculosis never dies, and the mortality is proportionately, and in the long run actually greater than that of the yellow plague. In the present epidemic at New Orleans about 14% of the infected die, while the same figure expresses the proportion of deaths from tuberculosis to all deaths. In the city of Charleston alone in the last twelve years 3,106 people have died of this disease—a yearly average of more than 250. But it occasions no comment, not the slightest ripple of excitement. When yellow fever is threatened ordinances are passed and enforced, extraordinary efforts are made to cleanse and disinfect with unusual thoroughness, the public are taught how the dread disease is propagated and spread, and what must be done to avoid infection in case the plague should reach us. With the knowledge of past epidemics in our minds, and in full view of the injurious effects of the present epidemic, it cannot and should not be otherwise. But we plead for the same active struggle against the deadlier malady, the great hungry plague that is never absent from our borders, and is unceasing in its work of destruction. We plead for greater care on the part of physicians in making early diagnoses; for methodical instruction of the masses concerning the contagious nature of consumption and the means to be employed for its prevention; and for the application by municipal health authorities of measures for the destruction of the germs and the prevention of their spread. The notification of tubercular cases is essential for the proper carrying out of these measures, and notification should be obligatory as in the case of smallpox or diphtheria, and not left to the discretion of the attending physician. If physicians and municipal authorities would show a united front and manifest in the fight against tuberculosis an interest and energy equal to that which they display in the combat with yellow fever and smallpox and diphtheria the disappearance of consumption would be a matter of time only.



"I hold that man has already reached a position of intelligence and responsibility in which he becomes a co-worker with the Creator in the betterment of himself and his brother. Our future lies largely in our own hands. Shall we move onward toward the promised land of human perfection, or shall we admit that life is a failure and that the race is without the opportunity of betterment? If we can make this world a fairer habitation for happier and better generation we should seek no nobler task and ask no higher reward!"

VICTOR C. VAUGHN.

#### THE NEW PRESIDENT OF THE A. M. A.

The American Medical Association is to be congratulated upon the selection of a thoroughly practical man as President. Dr. Wm. J. Mayo, of Rochester, Minn. In addition to being a surgeon of the very first rank and one who has done as much as any man to forward American surgery by his work upon the Gall Bladder, is a charming gentleman and one well fitted to hold the Presidency of the Association.

There is one thing to be said about the American Medical Association, and that is that she seems to seek the man and not have the man seek the Association.

You may talk about the cliques in the American Medical Association, and you may talk about the two, three, four or five men power; but the fact remains and stands boldly forth, especially of recent years, that their selections for President have been of the very first order. One year we see so eminent a medical man as Dr. Musser, of Philadelphia, and the next year so eminent a surgeon as Dr. Mayo, of Rochester, at the helm.

Under the guidance of such men as these, and with the many State Journals that are now being published, it is ridiculous in the extreme to say that the American Medical Association is degenerating into a body that is run by a clique. No clique can capture an Association with every State Journal as a mouthpiece, and every well known scientific man as a factor in her well-being.

We congratulate the Association on the selection of Dr. Mayo, of Rochester.

#### DR. OSLER'S FAREWELL.

We publish in this issue Dr. Wm. Osler's farewell address to the Medical Profession of the United States, and sincerely trust that each and every member who receives this copy, will read it thoroughly, digest it thoroughly, and think upon it thoroughly. Unity, peace and concord is the subject of this eminent medical man's farewell, and it is well worth the time taken in the reading and the after thought and consideration thereof.

Dr. Osler has gone to accept the highest honor that it is possible to attain in the world of medicine. Being Regius Professor of Medicine at Oxford means that he has passed over all of the bridges, all of the rivers, passed all of his colleagues, and has attained the highest point upon the pinnacle of medical fame.

It is said by those who have toiled up the snowy declivities of Mt. Blanc and reached the top, that the sense of well done is the sole return for the hardships of that toilsome journey. In other words, it is the accomplishment of the feat that thrills. We trust that Dr. Osler is experiencing this most delightful of all sensations—conquest, and we wish him well; and trust that still further honors, if any, await him, will fall to his share. That he deserves them, no medical man in this broad United States of America will gainsay.

We heartily recommend his farewell address to each and every one of our readers.

#### FEES OF INSURANCE EXAMINERS.

In the issue of *American Medicine* of Sept. 2nd, there appears a most excellent editorial on the subject of small fees of the Medical Examiners. The editorial states that the average fees are from \$1.00, \$2.00 or 3.00. When we consider that this might mean to the Insurance Company thousands of dollars, the fee is farcical on its face. The Doctor who passes on the risk gets a fee absolutely disproportionate. The editorial suggests that instead of giving

\$20,000 as annual retainers to men who do nothing, as was recently shown in the affairs of the Equitable, it would be far better for the Insurance Companies to pay the Medical Examiners better fees for their examinations, in order that it would pay them to take more time to make thorough examinations, and thus protect the policy holders and the Company.

The editorial suggests that the proper fee for the Medical Examiner is one-half of 1% of the face value of the policy, or even 1%, and states that such gradation of fees is in accordance with the legal custom of ages and that public policy really demands it, and if this were the case it would be an attractive specialty, and one that would attract able men to the betterment of the Company and of the insured.

#### AS OTHERS SEE US.

Four more State Medical organizations have started medical journals as the medium of publication of their transactions, and one, Maryland, has made an existing journal its official publication. Texas, Ohio, South Carolina and New Mexico are the States to begin the publication of new journals, and we certainly wish them the very best of success and long and useful lives. The acceptance of the journal idea by comparatively small organizations, such as South Carolina and New Mexico, is very suggestive, and is a lesson to some of the larger organizations which as yet are undecided. The fact that the members of a society can in this manner be reached every month in the year, and not merely once a year, at the annual meetings, is undoubtedly one of the strongest arguments in favor of the State organization journal. The action of the A. M. A. in establishing the Council on Pharmacy and Chemistry furnishes a good and safe guide for the benefit of those who have charge of the business management of State Medical Association Journals, and there seems little reason to doubt that they can come together on a common ground and effect

an organization of State medical journals that will be of great usefulness and advantage to all. The four new journals have started right, and there is no reason why, under the advice of the Council, they should not continue right; we believe that they will, and we certainly wish them well.—*California State Journal of Medicine*.

#### UNITY, PEACE AND CONCORD.\*

Farewell Address to the Medical Profession of the United States.

BY

WILLIAM OSLER, M. D.,

Regius Professor of Medicine, Oxford University,

OXFORD, ENGLAND.

On this occasion I have had no difficulty in selecting a subject on which to address you. Surely the hour is not for the head but for the heart, out of the abundance of which I may be able to express, however feebly, my gratitude for the many kindnesses I have received from the profession of this country during the past twenty-one years, and from you, my dear colleagues of this State and city, during the sixteen years I have dwelt among you. Truly I can say that I have lived my life in our beloved profession—perhaps too much! but whatever success I have had has come directly through it, and my devotion is only natural. Few men have had more from their colleagues than has fallen to my lot. As an untied young man my appointment at McGill College came directly through friends in the faculty who had confidence in me as a student. In the ten happy years I lived in Montreal I saw but few physicians and students, among whom I was satisfied to work—and to play. In Philadelphia the hospitals and societies absorbed the greater part of my time, and I lived the peaceful life of a student with students. An ever-widening circle of friends in the profession brought me into closer contact with the public, but I have never departed from my ambition to be first of all a servant of my brethren, willing and anxious to do anything in my power to help them. Of my life here you all know I have studied to be quiet and to do my own business and to walk honestly toward them that are without, and one of my chief pleasures has been to work among you as a friend, sharing actively in your manifold labors. But when to the sessions of sweet silent thought I summon up the past, not what I have done, but the many things I have left undone, the opportunities I have neglected, the battles I have shirked, the precious hours I have wasted—these rise up in judgment.

A notable period it has been in our history through which we have lived, a period of reconstruction and renovation, a true renaissance, not only an extraordinary revival of learning, but a complete transformation in our educational methods; and I take pride in the thought that, in

\*Delivered at the annual meeting of the Medical and Surgical Faculty of Maryland, Baltimore, April 26, 1905. Reprinted from the Journal of the A. M. A., August 5, 1905..



Philadelphia and in Baltimore, I have had the good fortune to be closely associated with men who have been zealous in the promotion of great reforms, the full value of which we are too close to the events to appreciate. On the far-reaching influence of these changes time will not permit us to dwell. I propose to consider another aspect of our work of equal importance, neither scientific nor educational, but what may be called humanistic, as it deals with our mutual relations and with the public.

Nothing in life is more glaring than the contrast between possibilities and actualities, between the ideal and the real. By the ordinary mortal, idealists are regarded as vague dreamers, striving after the impossible, but in the history of the world how often have they gradually molded to their will conditions the most adverse and hopeless! They alone furnish the *Geist* that finally animates the entire body and makes possible reforms and even revolutions. Imponderable, impalpable, more often part of the moral than of the intellectual equipment, are the subtle qualities so hard to define, yet so potent in every-day life by which these fervent souls keep alive in us the reality of the ideal. Even in a lost cause with aspirations utterly futile, they refuse to acknowledge defeat and, still nursing an unconquerable hope, send up the prayer of faith in face of a scoffing world. Most characteristic of aspirations of this class is the petition of the Litany in which we pray that to the nations may be given "unity, peace, and concord." Century after century from the altars of Christendom this most beautiful of all prayers has risen from lips of men and women, from the loyal souls who have refused to recognize its hopelessness, with the war drums ever sounding in their ears. The desire for unity, the wish for peace, the longing for concord, deeply implanted in the human heart, have stirred the most powerful emotions of the race, and have been responsible for some of its noblest actions. It is but a sentiment, you may say, but is not the world ruled by feeling and by passion? What but a strong sentiment baptized this nation in blood, and what but sentiment, the deep-rooted affection for country which is so firmly implanted in the hearts of all Americans, gives to these States to-day unity, peace, and concord. As with the nations at large, so with the nation in particular, as with people so with individuals, and as with our profession so with its members, this fine old prayer for unity, peace and concord, if in our hearts as well as on our lips, may help us to realize its aspirations. What some of its lessons may be to us will be the subject of my address.

UNITY.—Medicine is the only world-wide profession, following everywhere the same methods, actuated by the same ambitions and pursuing the same ends. This homogeneity, its most characteristic feature, is not shared by the law, and not by the church, certainly not in the same degree. While in antiquity the law rivals medicine, there is not in it that extraordinary solidarity which makes the physician at home in any country, in any place where two or three sons of men are gathered together. Similar in its high aims and in the devotion of its officers, the Christian Church, widespread as it is, and saturated with the humanitarian instincts of its Founder, yet lacks that catholicity—*urbi et orbi*—which enables the physician to practise the same art amid the same

surroundings in every country of the earth. There is unity, too, in its aims—the prevention of diseases by discovering their causes, and the cure and relief of sickness and suffering. In a little more than a century a united profession working in many lands has done more for the race than has ever before been accomplished by any other body of men. So great have been these gifts that we have almost lost our appreciation of them. Vaccination, sanitation, anesthesia, antiseptic surgery, the new science of bacteriology, and the new art in therapeutics have effected a revolution in our civilization to which only can be compared the extraordinary progress in the mechanical arts. Over the latter there is this supreme advantage, it is domestic—a bedroom revolution, which sooner or later touches each one of us, if not in person, in those near and dear—a revolution which for the first time in the history of poor, suffering humanity brings us appreciably closer to that promised day when the former things should pass away, when there should be no more unnecessary death, when sorrow and crying should be no more, and there should not be any more pain.

One often hears as a reproach that more has been done in the prevention than in the cure of disease. It is true, but this second part of our labors has also made enormous progress. We recognize to-day the limitations of the art, we know better the diseases curable by medicine, and those which yield to exercise and fresh air; we have learned to realize the intricacy of the processes of disease and have refused to deceive ourselves with half knowledge, preferring to wait for the day instead of groping blindly in the dark or losing our way in the twilight. The list of diseases which we can positively cure is an ever-increasing one, the number of diseases the course of which we can modify favorably is a growing one, the number of incurable diseases (which is large and which will probably always be large) is diminishing—so that in this second point we may feel that not only is the work already done of the greatest importance, but that we are on the right path, and year by year as we know disease better, we shall be able to treat it more successfully. The united efforts of countless workers in many lands have won these greatest victories of science. Only by ceaseless co-operation and the intelligent appreciation by all of the results obtained in each department has the present remarkable position been reached. Within a week or ten days a great discovery in any part of the world is known everywhere, and, while in a certain sense we speak of German, French, English and American medicine, the differences are trifling in comparison with the general similarity. The special workers know each other and are familiar with each other's studies in a way that is truly remarkable. And the knowledge gained by the one, or the special technic he may devise, or the instrument he may invent is at the immediate disposal of all. A new life-saving operation of the first class devised by a surgeon in Breslau would be performed here the following week. A discovery in practical medicine is common property with the next issue of the weekly journals.

A powerful stimulus in promoting this wide organic unity is our great international gatherings, not so much the International Congress of the profession, which has proved rather an unwieldy body, but of the special societies which are rapidly denationalizing science. In nearly

every civilized country medical men have united in great associations which look after their interests and promote scientific work. It should be a source of special pride to American physicians to feel that the national association of this country—the American Medical Association—has become one of the largest and most influential bodies of the kind in the world. We can not be too grateful to men who have controlled its course during the past ten years. The reorganization so efficiently carried out has necessitated a readjustment of the machinery of the State societies, and it is satisfactory to know that this meeting of our State Society, the first held under the new conditions, has proved so satisfactory. But in the whole scheme of readjustment nothing commands our sympathy and co-operation more than the making of the country societies, the materials out of which the State and national associations are built. It is not easy at first to work out such a scheme in full detail, and I would ask of the members of this body not only their co-operation, but an expectant consideration, if the plan at first does not work as smoothly as could be desired. On the county members I would urge the support of a plan conceived on broad national lines—on you its success depends, and on you its benefit will chiefly come.

Linked together by the strong bonds of community of interests, the profession of medicine forms a remarkable world-unit, in the progressive evolution of which there is a fuller hope for humanity than in any other direction.

Concentration, fusion and consolidation are welding together various subunits in each nation. Much has been done, much remains to do, and to three desiderata I may refer briefly.

In this country reciprocity between the State licensing boards remains one of the most urgent local needs. Given similar requirements, and examinations practically of the same character, with evidence of good character, the State board should be given power to register a man on payment of the usual fee. It is preposterous to restrict in his own country, as is now done, a physician's liberty. Take a case in point: A few months ago a man who is registered in three States, an able, capable practitioner of twenty years' standing, a hard student in his profession, a physician who has had charge of some of the most important lives of this country, had to undergo another examination for license. What an anomaly! What a reflection on an united profession. I would urge you all most strongly to support the movement now in progress to place reciprocity on a proper basis. International reciprocity is another question of equal importance, but surrounded with greater difficulties and, though a long way off, it will come within this century.

The second urgent need is a consolidation of many of our medical schools. Within the past twenty-five years conditions have so changed that the tax on the men in charge of the unendowed schools has become ever more burdensome. In the old days of a faculty with seven professors, a school with 300 students was a good property, paying large salaries, but the introduction of laboratory and practical teaching has so increased the expenses that very little is now left for distribution at the end of the year. The students' fees have not increased proportionately, and only the self-sacrifice and devotion of men

who ungrudgingly give their time, and often their means, save a hopeless situation. A fusion of the schools is the natural solution of the problem. Take a concrete example: A union of three of the medical schools of this city would enable the scientific departments to be consolidated at an enormous saving of expense and with a corresponding increase in efficiency. Anatomy, physiology, pathology, physiologic chemistry, bacteriology and pharmacology could be taught in separately organized departments which the funds of the united school could support liberally. Such a school could appeal to the public for aid to build and endow suitable laboratories. The clinical work could be carried on at the separate hospitals, which would afford unequaled facilities for the scientific study of disease. Not only in this city, but in Richmond, in Nashville, in Columbus, in Indianapolis and in many cities a "merger" is needed. Even the larger schools of the larger cities could "pool" their scientific interests to the great advantage of the profession.

And the third desideratum is the recognition of our homeopathic brethren that the door is open. It is too late in this day of scientific medicine to prattle of such antique nonsense as is indicated in the "pathies." We have long got past the stage when any "system" can satisfy a rational practitioner, long past the time when a difference or belief in the action of drugs—the most uncertain element in our art!—should be allowed to separate men with the same noble traditions, the same hopes, the same aims and ambitions. It is not as if our homeopathic brothers are asleep—far from it—they are awake many of them at any rate—to the importance of the scientific study of disease, and all of them must realize the anomaly of their position. It is distressing to think that so many good men live isolated, in a measure, from the great body of the profession. The original grievous mistake was ours—to quarrel with our brothers over infinitesimals was a most unwise and stupid thing to do. That we quarrel with them now is solely on account of the old shibboleth under which they practice. Homeopathy is as inconsistent with the new medicine as is the old-fashioned polypharmacy, to the death destruction of which it contributed so much. The rent in the robe of Æsculapius, wider in this country than elsewhere, could be repaired by mutual concessions—on the one hand by the abandonment of special designations, and, on the other, by an intelligent toleration of the therapeutic vagaries which in all ages have beset the profession, but which have been mere flies on the wheels of progress.

PEACE.—Many seek peace, few pursue it actively, and among these few we, alas! are not often to be found. In one sense every one of us may be asked the question which Jehu returned to Joram: "What hast thou to do with peace?" since our life must be a perpetual warfare, dominated by the fighting spirit. The physician, like the Christian, has three great foes—ignorance, which is sin; apathy, which is the world, and vice, which is the devil. There is a delightful Arabian proverb, two lines of which run: "He that knows not and knows not that he knows not is a fool—shun him. He that knows not and knows that he knows not is a simple—teach him." To a large extent these two classes represent the people with whom we have to deal. Teaching the simple and suffering the fools gladly, we must fight the wil-



ful ignorance of the one and the helpless ignorance of the other, not with the sword of righteous indignation, but with the skillful weapon of the tongue. On this ignorance the charlatan and the quack live, and it is by no means an easy matter to decide how best to conduct a warfare against these wily foes, the oldest and most formidable with whom we have to deal. As the incomparable Fuller remarks: "Well did the poets feign Æsculapius and Circe brother and sister, \*

\* \* for in all times (in the opinion of the multitude) witches, old women and imposters have had a competition with doctors." Education of the public of a much more systematic and active kind is needed. The congress on quackery, which is announced to take place in Paris, with some twenty-five subjects for discussion, indicates one important method of dealing with the problem. The remarkable exhibit held last year in Germany of everything relating to quacks and charlatans did an immense good in calling attention to the colossal nature of the evil. A permanent museum of this sort might well be organized in Washington in connection with the Department of Hygiene. It might be worth while to imitate our German brethren in a special national exhibit, though I daresay many of the most notorious sinners would apply for large space, not willing to miss the opportunity for a free advertisement! One effective measure is enforced in Germany. Any proprietary medicine sold to the public must be submitted to a government analyst, who prepares a statement (as to its composition, the price of its ingredients, etc.), which is published at the cost of the owner of the supposed remedy in a certain number of the daily and weekly papers.

By far the most dangerous foe we have to fight is apathy—indifference from whatever cause, not from a lack of knowledge, but from carelessness, from absorption in other pursuits, from a contempt bred of self-satisfaction. Fully 25 per cent. of the deaths in the community are due to this accursed apathy, fostering a human inefficiency, and which goes far to counterbalance the extraordinary achievements of the past century. Why should we take pride in the wonderful railway system with which enterprise and energy have traversed the land when the supreme law, the public health, is neglected? What comfort in the thought of a people enjoying great material prosperity when we know that the primary elements of life (on which even the old Romans were our masters) are denied to them. What consolation does the "little red school house" afford when we know that a Lethan apathy allows toll to be taken of every class from the little tots to the youth and maidens? Western civilization has been born of knowledge, of knowledge won by hard, honest sweat of body and brain, but in many of the most important relations of life we have failed to make that knowledge effective. And strange irony of life, the lesson of human efficiency is being taught us by one of the little nations of the earth, which has so far bettered our instruction that we must again turn eastward for wisdom. Perhaps in a few years our civilization may be put on trial, and it will not be without benefit if it arouses the individual from apathy and makes him conscious of the great truth that only by earnest individual human effort can knowledge be made effective, if it arouses communities from an

apathy which permits medieval conditions to prevail without a protest.

Against our third great foe, vice in all its forms, we have to wage an incessant warfare, which is not less vigorous because of the quiet, silent kind. Better than any one else the physician can say the word in season to the immoral, to the intemperate, to the uncharitable in word and deed. Personal impurity is the evil against which we can do most good, particularly to the young, by showing the possibility of the pure life and the dangers of immortality. Had I time, and were this the proper occasion, I would like to arouse the profession to a sense of its responsibility toward the social evil—the black plague which devastates the land. I can but call your attention to an important society, of which Dr. Prince Morrow of New York is the organizer, which has for one of its objects the education of the public on this important question. I would urge you to join in a crusade quite as important as that in which we are engaged against tuberculosis.

CONCORD.—Unity promotes concord—community of interests, the same aims, the same objects give, if anything can, a feeling of comradeship, and the active co-operation of many men, while it favors friction, lessens the chances of misunderstanding and ill-will. One of the most gratifying features of our professional life is the good feeling which prevails between the various sections of the country. I do not see how it could be otherwise. One has only to visit different parts and mingle with the men to appreciate that everywhere good work is being done, everywhere an earnest desire to elevate the standard of education, and everywhere the same self-sacrificing devotion on the part of the general practitioner. Man will tell you that commercialism is rife, that the charlatan and the humbug were never so much in evidence, and that in our ethical standards there has been a steady declension. These are the Elijahs who are always ready to pour out their complaints, mourning that they are not better than their fathers. Few men have had more favorable opportunities than I have had to gauge the actual conditions in professional private life, in the schools, and in the medical societies, and as I have seen them in the past twenty years I am filled with thankfulness for the present and with hope for the future. The little rift within the lute is the absence in many places of that cordial professional harmony which should exist among us. In the larger cities professional jealousies are dying out. Read Charles Caldwell's "Autobiography" if you wish for spicy details of the quarrels of the doctors in the first half of the last century in this country. I am sorry to say, the professors have often been the worst offenders, and the rivalry between medical schools has not always been friendly and courteous. That it still prevails to some extent must be acknowledged, but it is dying out, but not so rapidly as we could wish. It makes a very bad impression on the public, and is often a serious stumbling block in the way of progress. Only the other day I had a letter from a most intelligent and appreciative layman who was interested in a large hospital scheme about which I had been consulted. I quote this sentence from it in sorrow, and I do so because it is written by a strong personal friend of the profession, a man

who has had long and varied experience with us: "I may say to you that one of the distressing bewilderments of the layman who only desires the working out of a broad plan is the extraordinary bitterness of professional jealousy between not only school men and non-school men, but between school men themselves, and the reflections which are cast on one another as belonging to that clique, which makes it exceedingly difficult for the layman to understand what way there is out of these squabbles."

The national and special societies, and particularly the American Medical Association, have brought men together and have taught them to know each other and to appreciate the good points which at home may have been overlooked. As Dr. Brush said yesterday in his address, it is in the smaller towns and country districts that the conditions are most favorable for mutual misunderstandings. Only those of us who have been brought up in such surroundings can appreciate how hard it is for physicians to keep on good terms with each other. The practice of medicine calls equally for the exercise of the heart and the head, and when a man has done his best, to have his motives misunderstood and his conduct of a case harshly criticised, not only by the family, but by a colleague who has been called in, small wonder when the opportunity arises, if the old Adam prevails and he pays in kind. So far as my observation goes there are three chief causes for the quarrels of doctors. The first is lack of proper friendly intercourse by which alone we can know each other. It is the duty of the older man to look on the younger one who settles near him not as a rival, but as a son. He will do to you just what you did to the old practitioner, when, as a young man, you started—get a good many of your cases; but if you have the sense to realize that this is inevitable, unavoidable and the way of the world, and if you have the sense to talk over, in a friendly way, the first delicate situation that arises, the difficulties will disappear and recurrences may be made impossible. The young men should be tender with the sensibilities of their seniors, deferring to their judgment and taking counsel with them. If young graduates could be taken more frequently as assistants or partners, the work of the profession would be much lightened and it would promote amity and good fellowship. A man of whom you may have heard as the incarnation of unprofessional conduct, and who has been held up as an example of all that is pernicious, may be, in reality, a very good fellow, the victim of petty jealousies, the mark of the arrows of a rival faction, and you may, on acquaintance, find that he loves his wife and is devoted to his children, and that there are people who respect and esteem him. After all, the attitude of mind is the all-important factor in the promotion of concord. When a man is praised, or when a young man has done a good bit of work in your special branch, be thankful—it is for the common good. Envy, that pain of the soul, as plato calls it, should never for a moment afflict a man of generous instincts and who has a sane outlook in life. The men of rival schools should deliberately cultivate the acquaintance of each other and encourage their students and the junior teachers to fraternize. If you hear that a young fellow just starting has made mistakes or is a little "off color," go out of your way to say a good

word to him, or for him. It is the only cure; any other treatment only aggravates the malady.

The second great cause is one over which we have direct control. The most widespread, the most pernicious of all vices, equal in its disastrous effects to impurity, much more disastrous often than intemperance, because destructive of all mental and moral nobility, as are the others of bodily health, is uncharitableness—the most prevalent of modern sins, peculiarly apt to beset all of us, and the chief enemy to concord in our ranks. Oftentimes it is a thoughtless evil, a sort of tic or trick, an unconscious habit of mind and tongue which gradually takes possession of us. No sooner is a man's name mentioned than something slighting is said of him, or a story is repeated which is to his disadvantage, or the involuntary plight of a brother is ridiculed, or even his character is traduced. In chronic and malign offenders literally "with every word a reputation dies." The work of a school is disparaged, or the character of the work in a laboratory is belittled; or it may be only the faint praise that damns, not the generous meed from a full and thankful heart. We have lost our fine sense of the tragic element in this vice, and of its debasing influence on the character. It is interesting that Christ and the apostles lashed it more unsparingly than any other. Who is there among us who does not require every day to lay to heart that counsel of perfection; "Judge not according to the appearance, but judge righteous judgment." One of the apostles of our profession, Sir Thomas Browne, has a great thought on the question:

"Whilst thou so hotly disclaimest the evil, be not guilty of diabolism. Fall not into one name with that unclean spirit, nor act his nature who thou so much abhorrest; that is, to accuse, calumniate, backbite, whisper, detract, or sinistrously interpret others. Degenerate depravities, and narrow-minded vices! not only below St. Paul's noble Christian, but Aristotle's gentleman. Trust not with some that the Epistle of St. James is apocryphal, and so read with less fear that stabbing truth, that in company with this vice thy religion is in vain. Moses broke the tables without breaking of the law; but where charity is broke the law itself is shattered, which can not be whole without love, which is the fulfilling of it. Look humbly upon thy virtues; and though thou are rich in some, yet think thyself poor and naked without that crowning grace, which thinketh no evil, which envieth not, which beareth, hopeth, believeth, endureth all things. With these sure graces, while busy tongues are crying out for a drop of cold water, mutes may be in happiness, and sing the Trisagion in heaven.

And the third cause is the wagging tongue of others who are too often ready to tell tales and make trouble between physicians. There is only one safe rule—never listen to a patient who begins with a story about the carelessness and inefficiency of Dr. Blank. Shut him or her up with a snap, knowing full well that the same tale may be told of you a few months later. Fully half of the quarrels of physicians are fomented by the tittle tattle of patients, and the only safeguard is not to listen. Sometimes it is impossible to check the flow of imprecation and slander, and then apply the other rule—perfectly safe, and which may be commended as a good practice—never believe what a patient tells you to the de-



triment of a brother physician, even though you may think it to be true.

To part from the profession of this country and from this old faculty, which I have learned to love so dearly, is a great wrench, one which I would feel more deeply were it not for the nearness of England, and for the confidence I feel that I am but going to work in another part of the same vineyard, and were it not for the hope that I shall continue to take interest in your affairs and in the welfare of the medical school to which I owe so much. It may be that in the hurry and bustle of a busy life I have given offense to some—who can avoid it? Unwittingly I may have shot an arrow o'er the house and hurt a brother—if so, I am sorry and I ask his pardon. So far as I can read my heart I leave you in charity, with all. I have striven with none, not, as Walter Savage Landor says, because none was worth the strife, but because I have had a deep conviction of the hatefulness of strife, of its uselessness, of its disastrous effects, and a still deeper conviction of the blessings that come with unity, peace and concord. And I would give to each of you, my brothers—you who hear me now, and to you who may elsewhere read my words—to you who do our greatest work laboring, incessantly for small rewards in towns and country places—to you the more favored ones who have special fields of work—to you teachers and professors and scientific workers—to one and all, throughout the length and breadth of the land—I give a single word as my parting commandment:

"It is not hidden from thee, neither is it far off. It is not in heaven that thou shouldst say, 'Who shall go up for us to heaven, and bring it unto us that we may hear it and do it?' Neither is it beyond the sea that thou shouldst say, 'Who shall go over the sea for us and bring it unto us that we may hear it and do it?' But the word is very nigh unto thee, in the mouth and in thy heart, that thou mayest do it—Charity."

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## ORIGINAL ARTICLES.

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### FOREIGN BODIES IN THE LARYNX, TRACHEA AND BRONCHI.

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DR. H. R. BLACK, SPARTANBURG, S. C.

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By sudden inspiration a foreign body, usually while being held in the mouth, is drawn into the air passage. Immediately it excites a violent paroxysm of coughing, and the body is ejected—producing no effect except a momentary sense of suffocation—or, if it becomes impacted, it may cause immediate death by occlusion of the glottis; elsewhere, it gives rise to acute inflammation, ulceration, great swelling and suppuration, with all the symptoms of laryngeal stenosis, as pain, cough, dyspnoea and aphonia,

With the laryngoscope the body may be seen above or below the vocal chords, and removed with a pair of laryngeal forceps, guided by the mirror, but this is hardly possible in young children. However, with the tip of the left index finger resting upon the body, or immediately behind it as a guide, the body can usually be extracted with a pair of long forceps.

If in the trachea a loud rhonchous may be heard on auscultation, a deep expiration will give rise to a severe cough with violent dyspnoea.

A foreign body impacted in a bronchus is always a grave accident, and is indicated by localized pain and cough. The respiratory murmur of one lung, or lobe, is lost, according to the location of the body. If it remains impacted, it gives rise to serious pulmonary changes, i. e., septic bronchitis, pneumonia, gangrene, suppuration, etc., and the patient is lost, or, after a prolonged illness, it is finally coughed up and the patient makes a recovery.

These are a few of the prominent symptoms of foreign bodies in the air passage—a full description of which will be found in any of our text-books on surgery.

#### REPORT OF CASE.

CASE I.—May 10th, 1903, a colored lad, aged seventeen years, came to my office with a cockle-burr in the larynx. There was much pain and a very rough cough, and loss of voice.

After the throat was cocaineized, a dark body could be seen—by the aid of a mirror—lying between the vocal chords anteriorly.

The mouth-gag was inserted and held securely in position by an assistant. The tip of the left index finger was carried down into the larynx, and brought directly in contact with the foreign body, which was easily and quickly removed with a pair of long forceps. This patient was referred to me by Dr. W. J. Wall, Innman, S. C.

The accident happened while the lad was plowing—the single-tree dislodging the burr from the bush, it flew into his

mouth and was drawn into the larynx before the lad could recover himself.

CASE 2.—November 15, 1903, Clarence S——, white, age seven years, while holding a cockle-burr between his teeth, blowing and drawing the air through it, sucked it into the larynx. He was brought to my office by Dr. Parsons, of Woodruff, S. C. He was suffering from the usual symptom—pain, hoarseness, loss of voice, cough, swelling, dyspnoea, etc.

In the erect position, seated on his father's lap with a sheet thrown over his chest and front to assist in controlling his arms, and with the mouth-gag secured in position by Dr. Parsons, the burr was located imbedded in the right chord by the tip of the finger. It was easily removed in the manner as above described.

CASE 3.—A colored boy, aged seven years, was referred to me by Dr. Wm. F. Smith, of Glenn Springs, S. C., with a cockle-burr in his throat—January, 1904.

It was lying well between the vocal chords, and was recognized and extracted in the usual manner twenty-four hours after it had been drawn into the larynx.

CASE 4.—September, 1904, S. W——, a negro lad of seventeen summers, while walking through a field, struck a cockle-burr bush with his foot, dislodging one, which flew into his mouth and was drawn into the larynx. Pain, cough, swelling, dyspnoea and aphonia immediately followed. In the proper position, with the mouth well open, the operator's left index finger was passed well down into the throat, and the tip made to sweep over the entire field—I thought—but failed to locate the body. Another effort was made, carrying the tip of the finger directly down upon the cricoid cartilage, then bringing it directly forward, well down into the larynx. I detected the burr deeply imbedded anteriorly between the chords. I then pushed the point of a pair of McKenzie's long forceps down over the palmar surface of the finger until they came in contact with the foreign body, at which moment the patient brought a most violent and terrific cough, which dislodged the burr, and he blew it out of his mouth.

In looking for a foreign body in the air passage, never open the wind-pipe until you are quite sure that it is not somewhere impacted in the larynx. If in the upper portion, or between the chords, you can usually remove them as I have indicated—guided by a mirror—cocaine to the pharynx and larynx will facilitate this measure—otherwise, you can choose between thyrotomy, laryngotomy and tracheotomy.

Cockle-burrs are usually imbedded in the chords, or the soft parts above. The needles take hold of the tissue whenever they meet the slightest resistance.

CASE 5.—January 31, 1905. Dr. W. G. Sexton asked me to see S. H——, white, female—aged nineteen months—whose parents said she had swallowed a safety-pin. At the time of my visit, there was no objective evidence of a foreign body in the throat, except a profuse flow of saliva. With the child securely held, in the proper position, I passed my finger into the throat, where I felt the pin, and the same was quickly removed. The pin was open.

CASE 6.—Brandon H——, aged four years, white, was referred to me by Dr. J. W. Bramlett, of Campobello, S. C., May 14, 1903, in the early part of the night, with a grain of corn impacted in the right bronchi at the bifurcation. He came to me seven days after the accident. His condition was a very distressed one, and, apparently, he could not survive many hours.

Drs. Dean and Jeffries were requested to assist in the operation. In an hour's time, the little fellow was lying upon the table with his wind-pipe open. The grain of corn was immediately blown out, and fell upon the floor.

The wound was cleansed and a tracheotomy tube inserted. The patient was dressed and put to bed. At the end of twenty-four hours, the tube was removed and the wound was dressed sufficiently thereafter to keep clean. He made a quick recovery and left for his home—eighteen miles away on the eighth day. There was no indication of inflammation or pneumonia at the time of the operation, or at any time thereafter—due, per-



haps, to the fact that the grain of corn had been boiled. The reader, however, can decide that for himself.

CASE 7.—January 1st, 1905, Hilder P——, white, age nineteen months, was referred to me by Dr. Parsons, of Woodruff, S. C., with the history of a foreign body of eight days duration in the throat. The nature of which was uncertain. While playing with a basket of nuts, the child became suddenly choked, almost strangulated, turned black in the face. The nurse was uncertain as to what had happened, but said that she thought that she saw something black go down the child's throat. Evidently, there was something in the larynx. The child was hoarse, could not speak above a whisper, and the breathing was difficult and quick, the pulse rapid, the temperature 98°.

I ordered her sent to the Spartanburg Hospital for an operation, which was complied with immediately. Drs. Heinitsh, Jeffries and Sexton were summoned to assist in the operation.

While the patient was held in the lap of one of the physicians, and the mouth-gag held by another, I passed the left index finger down into the larynx, where I could feel the sharp end of a foreign body with the tip of the finger. It was situated deeply, anteriorly, and just below the vocal chords. I made a single effort to extract it through the mouth, but in this I failed, and feared that I might push it farther down.

After some delay, the child was placed upon the operating table, and tracheotomy performed in the usual way—high operation. After incising the two first rings, a half-ounce of pus rolled out of the trachea. Sponging this away, a bright-looking substance—apparently, a nail—came into view. This object was removed with a pair of hoemastats, and proved to be a poultry wire staple—like the one I pass around.

A tracheotomy tube was left in position. The temperature went up to 101° and the pulse to 120. At the end of twenty-four hours, the tube was removed, the temperature dropped, and the pulse slowly returned to its normal beat.

The child made a fine recovery and left the hospital on the eighth day.

While discussing foreign bodies in the larynx, or air passage, I beg to report briefly eight more cases of intubation.

At the Association meeting in Spartanburg, S. C., three years ago, I reported four cases—three recoveries and one death. The latter was due to the lack of antitoxin, and the tube was not inserted until after the child had been desperately ill for more than a week.

#### CASES OF INTUBATION.

CASE 5.—Wm. F. T——, white, aged four years. Diagnosis—laryngeal diphtheria. This was a patient of Dr. T. D. Hairston, of Clifton No. 1, six miles east of Spartanburg, S. C. The patient was intubated November 12, 1902, and extubated five days thereafter. His recovery was speedy and complete.

CASE 6.—November 23, 1902, I was called by Dr. Walker, of Glendale, a mill town six miles east of Spartanburg, S. C., to intubate Randolph W——, white, aged ten months, the youngest I have ever seen with diphtheritic laryngitis.

Both tonsils were covered with the deposit, and the little fellow's condition was very alarming. The tube was inserted and in a few moments he fell asleep, and relief was complete. On the fifth day it was removed, only to be re-inserted. Two days later, it was again removed, but in an hour's time the breathing had become so labored that the tube had to be re-inserted for the third time. On the tenth day, it was finally extubated, and the patient made a happy recovery.

The younger the patient, the longer the tube must remain in the larynx. Notwithstanding the presence of the tube in the larynx, young children nurse about as well with a tube as they do without one.

CASE 7.—October 22, 1903, I was called by Dr. Allen, of Cedar Springs, S. C., to intubate the two-year old daughter of Wm. V. White. Diagnosis:—Laryngeal croup.

In less than ten minutes after my arrival, I had placed a tube in the larynx.

It was coughed out on the fourth day; the child was relieved and made a quick recovery.

CASE 8.—September 23, —, I was requested by Dr. J. L. Jeffries, of Spartanburg, S. C., to intubate the four-year old son of Ozra L———. Diagnosis:—Malignant diphtheritic laryngitis.

The tube was introduced on the seventh day of illness, but did not afford relief. The dyspnoea continued, due, perhaps, to the fact that the tube did not extend beyond the obstruction. Possibly it was cardiac, or due to toxæmia. However, the child was thoroughly septic. There was great swelling of the cervical lymph glands, and infiltration of the cellular tissue. The exudate, a dirty gray, covered both tonsils and the uvula. The pulse was rapid, feeble and compressible.

The tube was removed in less than an hour, and the little patient died on the following day. During the intervening hours, the distress was great. This child was subject to attacks of tonsillitis, for which reason the calling of a physician was delayed until the sixth day of its illness.

Antitoxine was given freely, but too late.

CASE 9.—Jessie S——, aged two years, patient of Dr. W. G. Sexton, Spartanburg, S. C., was intubated October 8th, 1903, and extubated five days thereafter. Recovery was very prompt.

CASE 10.—October 20, 1903, I was summoned to the bedside of J. S. H——, Jr., aged four years, white, at Clifton, No. 1, a mill town six miles east of Spartanburg, S. C., in consultation with Dr. T. D. Hairston. The doctor did not see this child until the day before—which was the seventh day of its illness. No antitoxine had been given, of course. Suffocation was threatening; a tube was placed in the larynx, from which there was no relief. The tube was removed in less than an hour, and the child laid upon a table and tracheotomy performed. Death was very prompt in its relief.

CASE 11.—R. W. White, male, aged one year, patient of Dr. G. H. Bunch,

Spartanburg, S. C., was intubated February 11, 1904.

On the third, fourth and fifth days, respectively, thereafter the tube was coughed up. At three o'clock A. M., a larger one was introduced, only to be coughed out at four different times—making seven times in all—and was finally disposed of on the eleventh day, the little fellow making a complete recovery.

CASE 12.—Son of P. W——, white, age nineteen months, of Pacolet Mills, twelve miles east of Spartanburg, S. C.; patient of Dr. Kirkpatrick, was intubated January 23, 1905.

The tube was removed on the seventh day; the dyspnoea returned, and the patient was re-intubated in less time than an hour. Two days later, the tube was coughed up; the breathing again became labored, and after a twelve-mile drive at a 2.40 gait—the tube was re-inserted.

On the twelfth day, the tube was again coughed up and disposed of, and a complete recovery followed.

#### DISCUSSION.

DR. C. M. WALKER:—My cases generally die before the 7th day. It seems to me the 7th day is a little late for intubation in cases of membranous croup.

DR. D. M. CROSSLAND:—I have listened with interest to Dr. Black's paper, as I have had my experience with foreign bodies in the throat. Sometime ago a man came hurriedly to me, and stated that while eating fish for breakfast he had gotten a fishbone in his throat. I examined his throat in every conceivable way and could not detect the bone, but he still said it was there. Not knowing what better to do, I took a piece of sponge, and wet it, and ran it down his throat and brought it back, and the fish bone was sticking in the sponge. He was relieved, and satisfied.

These things some time give you trouble. Some time ago I had a little child to swallow a small cartridge shell, and I had considerable trouble to get it out.

DR. MONSEN:—It is a fact worthy of note that reports of cases are usually uninteresting, but when they are reported in this way, so briefly, giving the rest of us credit for knowing a good deal, too, then they become interesting, and we can follow as lengthily a paper as this, with report of cases, with interest to the last. I think Dr. Black deserves credit for reporting cases in this way, and think it should be encouraged. When he gives us credit for knowing something; puts his finger down and immediately removes it and goes on to the next case, that makes it interesting to a body of men supposed to be educated.

DR. W. P. DENDY:—I want to thank Dr. Black for what he has said on intubation. I have been



attending the meetings of the Association for years and this is the first I have heard on it. We doctors who live in small towns know the importance of it. You see a child suffering, choking to death, and use a tube, and you know what appreciation you get. The cases we used to get before we had antitoxin all died, but now it is my experience, with 6 or 8 cases lately, we save every one of them with tube and antitoxin. If a country doctor wants the mothers to love him, if he gets an intubation case and carries it around with him he will accomplish that result.

DR. W. P. PORCHER:—I cannot help congratulating Dr. Black on his extraordinarily good fortune, in being able first to diagnose and locate a foreign body in the larynx, and second to be able to remove it with the aid of forceps and without a laryngeal mirror. In fact I might say that I do not know, in my acquaintance with the laryngologists, of a foreign body ever being diagnosed below the vocal chords and without the laryngeal mirror. As a rule these foreign bodies are located above the vocal chords, very often upon them, and are removed with the aid of the mirror and forceps.

There was a woman, a very noted character, in Vienna, who would allow students, and especially those who had some acquaintance with the manipulation, to put a bead down on her vocal chords and remove it with the forceps. She used to charge forty cents, one guilder, for each operation, for the practice. When she found there was one who was at all skilled in the manipulation, she would allow them to do it for demonstration purposes. But she had wonderful tolerance of the vocal chords for presence of a foreign body.

A year ago I reported the case of a child who had sucked a small, green pine burr into the larynx,—or, she got it into her throat, and it had been pushed there by the physician passing his finger in, trying to get it out. The great danger of using the finger is the danger of shoving the foreign body into the larynx, and perhaps into the bronchial tubes, followed by foreign body pneumonia. The pine burr had stayed in there long enough to be softened, the leaves being turned down, while endeavoring to catch it with the forceps the leaves would pull off, leaving the body in there. The father insisting that I continue my efforts to get it out, contrary to my own advice, the very thing occurred that I feared: it went into the larynx and the patient stopped breathing. I put a tracheotomy tube in, and the following day the pine burr was removed through the natural passages.

The point is this. Dr. Black states these tubes were applied and removed on the following day. One week after this tube was put in position, Dr. Rhett saw the case with me, and thought the tube could be removed in 36 hours. We attempted it, and the breathing stopped, and we had to replace the tube. At the end of a week it was attempted, but it was 21 days before the tube could be removed with any chance of the patient's life. I am glad to say the patient got well, and is a hale, hearty child.

I congratulate Dr. Black on his good luck.

DR. WHALEY:—Dr. Porcher has mentioned a celebrated character in Vienna with whom I was acquainted. She was a wonderful woman. She would take a piece of bone, about the size of a buck-shot, and would put it in any one of the folds you wanted to take it out of. Her charge

was forty cents an hour. It is said that woman taught more men how to operate in the larynx than any physician that ever lived. She was a wonderful woman, and I do believe she ought to have a monument.

DR. G. B. EDWARDS:—I have listened to Dr. Black's remarks with interest. We had an epidemic a few years ago in our town. The first case was sporadic, and naturally there was some difficulty in making a diagnosis. In that case, unfortunately, the membrane appeared low down, and appeared to be an ordinary case of tonsilitis, and before we knew it the other symptoms appeared, and we tried intubation without any success, and the only thing left for us was tracheotomy. My brother and myself performed the operation, and in that case we saved the patient by tracheotomy.

In regard to coughing up the tube. I was called in the country to a child that had been operated on and had coughed up the tube, and I used another tube and got relief. That was late in the afternoon. The next morning, about four o'clock, I was sent for again. I sent off to another town and got another tube, and when I got there I found the child was considerably relieved, and I advised against introducing the tube again, and the child recovered. Twelve hours before, death seemed inevitable without intubation.

DR. BLACK:—I first want to thank the gentlemen for their kind and complimentary remarks in reference to my operations on the larynx especially. Why Dr. Porcher was not able to get rid of his tube any earlier than 21 days I don't know, but the tracheotomy tube in the larynx is a foreign body and I believe should be disposed of as soon as possible. However, there might be as much difficulty in disposing of a tracheotomy tube as there is sometimes in disposing of an intubation tube, because, while it has not happened in my experience, tubes in the larynx have been worn 30 to 60 days, and some, I believe, 90 days. However, I would suggest that whenever you put the tracheotomy tube in the trachea you get rid of it as early as possible, and make your effort the following day.

As to a shot lying on the vocal chords, or any of its folds, I don't care to have any one come to me to try my skill on that line, but if called I will do my best, and I don't wonder that the patient died, if it is the same case Dr. Whaley referred to. I would like to know if that patient died with a shot somewhere in the larynx, or one of its ramifications?

DR. WHALEY:—She has since died, of old age. I believe.

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## GASTROSTOMY IN STRICTURE OF THE ESOPHAGUS, WITH THE REPORT OF A CASE.

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BY

MANNING SIMONS, M. D.,

CHARLESTON, S. C.

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By gastrostomy is meant the establishment of a more or less permanent fistula opening into some part of the anterior

wall of the stomach for the purpose of alimmentation or surgical treatment.

It is almost always performed in esophageal stenoses for the purpose of feeding.

It is a development of modern abdominal surgery and may be regarded as one of the most humane operations, having for its object the aberation of the pangs of hunger and the amelioration of the sufferings of death from inanition.

The operation was first suggested by Egeberg, a Norwegian, in 1837, and was first performed by Sedillot, of Strasburg, in 1849.

The early operations upon the stomach for artificial feeding were almost invariably fatal. According to statistics collected by Gross up to 1884, the operation was attended by a mortality of 29.47. Senn estimates it at 25%.

As in most of the other life saving abdominal operations experience proves that it should not be regarded in the light of a 1st resort.

A review of the literature of the subject shows that the earlier operations have been performed under the most unfavorable conditions. Too often it has been put off until the patient, scarcely able to swallow liquids, is just kept alive by enemata.

Such patients worn out by the sufferings of slow starvation, and their strength reduced to the lowest ebb, by rapidly increasing emaciation, are not in a favorable condition to withstand the shock of abdominal section and plastic operation on the stomach.

As Jacobson puts it after an experience of gastrostomy performed twelve times, in each case for cancer of the esophagus, "I do not think that I exaggerate if I say that in a distinct proportion of the cases, in which the surgeon is asked to perform gastrostomy the hand of death is already on the patient, and something next door to the decomposition of the grave has already set in, owing to the extension of the disease."

The indications for gastrostomy are generally clear. The operation is demanded when the passage of food to the stomach is so obstructed as to interfere

seriously with nutrition, but it is advisable to make a gastrostomy for fistula much earlier than this.

In fact many authorities believe in performing the operation in cancerous stricture long before deglutition becomes difficult.

The circumstances under which gastrostomy may be indicated, are:—

1. Certain cases of cancerous stricture. This includes invasion of the esophagus, secondarily from primary cancer of the mediastinal glands.

2. Cancerous disease of the pharynx, and in a few cases malignant disease of the tonsil or back of the tongue not admitting of operation.

3. Cicatricial stricture, whether traumatic of syphilitic.

In stricture of the esophagus due to cancer, the operation of gastrostomy is manifestly only a palliative procedure, intended to prolong life and avert the suffering of a slow starvation, until such time as it may be terminated by progressive exhaustion or extension of the original cause of the disease.

No comparison can yet, however, be made in this class of cases between the operation of gastrostomy and treatment by tubes or other methods of dilatation, for the reason that the operation has heretofore been performed under the most unfavorable conditions, and reliable statistics are not available.

Even though dilatation be resorted to in such cases the time will probably come when tubes can no longer be employed, because of the tightness of the contraction, and the danger arising from hemorrhage or perforation in the effort.

If gastrostomy be deferred until such conditions be reached, it can be performed only with greatly increased risk and as a forlorn hope.

In cicatricial stricture the methods of treatment offer a wider field for gastrostomy than that of palliation only.

1. Direct dilatation, by dilating bougies or instruments of increasing sizes passed directly from the mouth through the narrowed esophagus, the stricture being gradually dilated.



2. Direct divulsion, by the passage from the mouth in quick succession of increasing sizes of dilators, thus rupturing, in a minor degree, the surrounding constricting tissues.

3. Division of the stricture by string friction, (Byant's operation).

4. Permanent tubage.

5. Internal esophagotomy.

In some cases, however, none of these methods can be employed, many of them come under the care of the surgeon after the contraction has become so extreme that it is impossible at once to pass an instrument from the mouth, a proceeding necessary to the employment of any of the methods proposed.

In other cases the irritation caused by the organic stricture may not only exaggerate the degree of constriction by exciting spasm of the muscular fibres of the tube in the immediate vicinity of the structure but also at points remote from the seat of organic lesion.

In this class of cases gastrostomy is a natural deduction from the difficulties enumerated.

By setting the oesophagus at rest for a time some of these complications are overcome as in the almost parallel case of stricture of the urethra.

In the mean time nutrition can be maintained by direct gastric alimentation.

Retrograde dilatation of the stricture may be resorted to. Here the dilating instrument is passed from below through a gastrostomy wound in cases where but one sitting of the retrograde method is necessary followed by the immediate closure of the stomach wound, or through a gastrostomy wound where frequent resorts to the method are necessary.

Dilatation may be begun by passage of the instrument from the stomach through the strictured esophagus, but it is often commenced by causing the patient to swallow prior to anaesthesia, a thread with a split shot attached. This is found in the stomach, and upon it the dilating rubber tubes or other instruments are drawn from the mouth through the esophagus out of the stomach wound or *vice versa*.

In the same manner division of the esophageal stricture by string friction (after Abbe's method) may be performed, after preliminary gastrostomy is done, and recovery from the operation has taken place.

The operation of gastrostomy may be done in one or two stages—where haste is a consideration the opening must be made into the stomach as soon as the latter is attached to the abdominal wall. Where haste is unnecessary the stomach is first attached to the opening in the anterior abdominal wall; from three to five days given for union to take place, shutting off the peritoneal cavity, and then the stomach is opened.

There is little objection to establishing the fistula at once if the peritoneum is tightly approximated to the wound.

In many cases of gastrostomy for esophageal stricture the patient has been starved so long that it is extremely desirable to feed him at once. The risk from opening the stomach are so slight in such cases that it seems desirable to make the opening immediately in spite of the slightly increased risk.

Much difference of opinion seems to exist as to the proper placing of the incision of the skin in the first step of the operation.

However, these opinions differ, it would seem the chief object to be attained is that muscles should be divided in their cleavage line in so far as this is possible and the abdominal nerves should be spared so far as is practicable.

A disadvantage of all oblique incisions parallel with and just below the left Costal arch is the difficulty in making an intro-muscular separation of the fibres. Experience has brought the incision nearer to the vertical. Jacobson, as a result of his experience in twelve cases, prefers as simpler than the oblique, a straight vertical incision beginning opposite the end of the eighth intercostal space and passing down for three inches over the rectus, that is about two inches from the linea alba.

According to Bickham the original Ssabamajew-Frank incision, has been

modified in this respect and is now less oblique.

The patient should be placed supine on the table, with the abdominal parietes relaxed by slight elevation of the shoulders and slight flexion of the hips, the very prominent angle formed between the ribs and the sunken umbilical region, offering one of the difficulties in the performance of the operation.

The fibres of the rectus being exposed are torn straight through with a director, and the posterior, somewhat concave, layer of its sheath exposed. This is carefully divided for the full length of the incision and the extra peritoneal fat (if present) and the peritoneum picked up and opened together. A finger is now introduced to feel for the stomach.

In all methods of gastrostomy care must be taken not to mistake the colon for the stomach. This error has been made by several surgeons.

There is generally no difficulty whatever in recognizing the characteristic appearance of the anterior wall. In most cases the stomach presents itself immediately at the incision, if the latter is made well above the umbilicus, whether in the median line or to the left.

The difficulties arising from contraction of the stomach in prolonged starvation may be great. As a rule the contracted stomach lies high up under the left lobe of the liver and requires to be hooked downwards and forwards into the wound.

Not infrequently the great omentum presents first, and it is easy by seeking too low down to draw up the colon.

In case of difficulty the best plan is to find the anterior border of the liver, trace up the under surface to the portal fissure, and then along the lesser omentum to the stomach.

This is told by its thicker, more substantial feel and pink red color.

The stomach being drawn up, a part is chosen on its anterior surface free from vessels, and as near as possible to the Cardiac end.

A number of different methods of completing the operation have been devised, the object being to prevent regurgitation

of stomach contents, by producing the longest, most indirect and most valvular canal possible between the stomach and abdominal openings.

The greater the degree reached in obtaining this object the greater the control over the gastric contents.

Doubtless these various methods have been suggested by the difficulties encountered in the individual cases in bringing up a contracted stomach into the abdominal wound and there fixing it, and at the same time attaining the objects above mentioned.

The scope of this paper will not permit a detailed account of the various methods that have been proposed and practiced.

Bickham has given a comparison of these methods that may enable the surgeon to select such as may suit individual cases.

The Ssabanajew-Frank method performed through the separate fibres of the rectus muscle is probably the best for a permanent fistula especially in a lax stomach.

Kader's method is probably best for small or adherent stomachs.

Marwedel's method is probably the best for the rapidity of healing of the fistula and Howese's method is probably most quickly done.

The operation performed in case reported below was that known as the Ssabanajew-Frank. So called because it was done in 1890 by Ssabanajew, of Odessa, and by Frank, in Vienna, in 1892.

The case is taken from the case book of the city hospital.

B. B., colored, male, aged 21, farmer, was admitted to the hospital Nov. 12th, 1904, during my service, with the following history:

He lived in the country, he said, and that his health had been good since childhood, except for chills and fever occasionally.

During the first week of January, 1904, he was given a drink of whiskey containing concentrated lye, which he drank. This was followed by intense pain in the stomach and nausea, but he was unable to secure the aid of a physician until the



third day after taking the dose mentioned.

When the physician reached him he was suffering with intense pain in the mouth, throat and stomach.

Vomiting was almost constant, the vomited matter being blood stained.

The abdomen was somewhat distended and tender on pressure; fever was high and the pulse weak and rapid. No examination was made of the urine for blood or albumen.

The case was discharged after the third visit. Nothing more was seen of the case until July 15th, when he came to the Dispensary Office very much emaciated and with a partial esophageal stricture.

An attempt was made to dilate the stricture but this was unsuccessful.

The patient was therefore sent to the City Hospital in Charleston, where he was admitted on July 24th, 1904.

He was nourished for a few days by nutrient enemata. On July 29th a gastrostomy by the Ssabahajew-Frank method was done by the surgeon in charge of the hospital.

The incision in the operation was made a little low and there was some doubt whether the stomach or intestine was attached to the abdominal wound.

A rubber tube was left in the opening through which the patient was fed for two weeks. Bougies were passed and the oesophagus dilated at the time.

The abdominal wound was allowed to close and he was discharged on Oct. 1st, 1904.

He was able to swallow and increased a good deal in weight. After his discharge he failed to pass the bougies and as a result the stricture of the oesophagus again contracted.

On November 12th, 1904, he was admitted to the hospital for the second time, and came under my care.

He was emaciated to an extreme.

"The emaciation, the prominent or almost uncovered muscles and bones, the expression of anxiety and suffering, the furrowed forehead, the sunken eyes, the open, sharply defined nostrils, the long, compressed lips, the depressed angles of the mouth and the deep curving around

these angles, denoted the sufferings of slow but certain starvation.

His exhausted, weak condition seemed almost to preclude the performance of an operation, and he was given nutrient enemata, together with other treatment calculated, it was hoped, to improve his general condition. Efforts to pass bougies through the oesophageal stricture proved unavailing.

On Nov. 17th, the operation for gastrostomy was done according to the Ssabahajew-Frank method.

The primary incision was made obliquely, three inches in length over the outer third of the left rectus muscle, beginning near the median line and passing downwards and outwards, somewhat more vertically than previously, though approximately parallel with and about one and a half inches from the left Costal arch. The vessels were clamped and the edges of the wound retracted.

The rectus muscle being thus exposed the anterior layer of its sheath was wider. The fibres of the outer part of the muscle were separated longitudinally by blunt dissection down to the posterior layer of the sheath, the transversalis fascia, subperitoneal areolar tissue and the peritoneum were successfully divided to the extent of the wound in the skin—preserving as much as possible the muscles and nerves. These structures were retracted as they were divided.

The abdominal cavity having thus been opened, two fingers were introduced and the stomach sought for. No difficulty was experienced in this procedure as the stomach was easily recognized by the touch.

A long cone of the anterior wall of the stomach was drawn through the abdominal wound by means of a silk traction ligature passing through the serous and muscular coats, the apex of the cone being represented by a part of the stomach wall nearer the greater than the lesser curvature and nearer the cardiac than the pyloric end.

Sufficient length of the cone was drawn out to pass without tension under a bridge work of skin about two inches wide.

The second coat of the stomach forming the base of the cone was now sutured

to the peritoneal and fascial edges of the wound with fine silk sutures.

The serous and muscular coats were then attached throughout to the posterior sheath of the rectus by a second tie of fine silk sutures, the danger of constriction being avoided.

A secondary incision three fourths of an inch in length was now made through the skin and fascia about one inch above the costal cartilage and approximately parallel with the first incision.

These incisions passed only into the connective tissue plane.

By blunt dissection from the larger to the smaller wound, the two were connected and the intervening bridge work of skin thus undermined along the fascial plane.

A pair of forceps passed through the smaller opening into the larger grasped the silk ligature and by this means the cone or the stomach was drawn into the smaller upper wound, over the edge of the lower costal cartilages, where it was held in place by silk sutures.

These sutures were passed through all the coats of the stomach on one side and through the skin and fascia on the other.

The small incision was sutured at either end, leaving a sufficient opening in the center for the passage of the cone.

The separated edges of the rectus and its sheath were now sutured with interrupted chromic cat gut from either end toward the center, leaving a sufficient opening to guard against dangerous constriction of the base of the cone, while at the same time approaching the base nearly enough to form a muscular circle about it.

The skin wound was closed with interrupted silk worm gut sutures. This having been accomplished, the apex of the cone was cut off, the mucous membrane everted and stitched to the serous coat.

A portion of stomach tube was then passed through the fistulous track, thus established into the stomach.

The patient lost but very little blood during the operation.

Before he was removed from the table an enteroclysis was administered, composed of a pint and half of normal salt

solution, an ounce of whiskey and thirty drops of a 1 to 100 solution of Adrenalin Chloride. This was repeated at intervals of three hours until he recovered from the shock of the operation.

As soon as he had recovered from the effects of the anaesthetic, feeding through the tube was commenced, but as no food had been received into the stomach for a long time nourishment was given cautiously and in small quantity. The nourishment consisted of beef tea, yolk of egg and milk.

The stomach tube was kept continuously in place for one week, after this time it was removed tentatively, but had to be replaced because of leakage of gastric juice and regurgitation of food.

The wounds healed well and it was found that the tube could be removed without being followed by leakage.

From this time the tube was introduced only at regular intervals for the purpose of feeding. As he progressed towards recovery he masticated his food before it was introduced into the stomach.

The stricture of the oesophagus was dilated from day to day with bougies until he was discharged, Jan. 15th, 1905. He could swallow and had increased in weight at this time. He was instructed to pass a bougie himself, but the gastric fistula was not closed lest there should be a recurrence of a tight contraction of the esophagus as on the previous occasion.

In the study of this subject I am indebted to the articles of Bickman, Jacobsen, Wyeth and Dennis.

#### DISCUSSION.

MR. MONSEN:—I would like to have the doctor state if he experienced any difficulty in passing any bougies up the esophagus, and how that operation was done so as to be successful?

DR. H. A. ROYSTER, of Raleigh, N. C.:—I hesitate to discuss each paper as it comes up, but I am interested in so many I cannot refrain, and especially as Dr. Simons has asked me to say something I feel constrained to do so.

My experience is limited to one case, with a child two years old, who had a traumatic stricture of the esophagus, produced by concentrated lye, and the case being seen by me two months after the occurrence. The child presented a typical case of starvation, so graphically described by Dr. Simons. I did an operation according to the Coder method, making a straight incision through the left rectus, bringing the stomach up, and putting sutures in one, then the other,



outlining the space through which it is necessary to introduce the tube. These sutures were held up as described, and an incision made into the stomach sufficient to admit the tube, the tube placed in position and these purse strings tautened, the first holding in the stomach, this way, and the second folding in still more, thus holding the tube in position. Silk-worm gut sutures were then passed through and through the abdominal incision, taking up a portion of the stomach wall in their grasp in order to hold the position. The result of the case was unfortunate, because the child died next morning, from the result of the wasting away and the shock of the operation.

I did not succeed in introducing any bougies into the esophagus. I had great difficulty, so much so that I felt that the operation was prolonged unduly and let that go until a later period; the child not being able to stand a very prolonged operation.

The results of this operation if done early are always good, but if done late are nearly always bad.

To show how some men regard these strictures of the esophagus. This case was kept under the care of a physician in the country, who stated to the family that this stricture could be dilated by giving food to the patient, and he kept it under advisement, without introducing any instrument at all, saying the food would help to dilate the stricture. That only shows how these cases are delayed in the hands of practitioners frequently until referred too late to the surgeon.

DR. PATTERSON:—I have had a good deal of experience with stricture of the esophagus from the same cause, concentrated lye, and I think it would be a good idea for the medical Association to attempt to have some laws inaugurated preventing the indiscriminate use of concentrated lye. It is certainly the cause of more accidents than almost any drug we have.

The treatment I have resorted to was gradual dilation with whalebone bougies. My experience is that food produces an impaction, and we have a total occlusion, and when it gets in that condition the only remedy is forcible dilatation, with a whalebone bougie. I have been able to relieve all these patients except, I think, two. I have treated 7 or 8. I reported some cases several years ago at one of our meetings.

DR. SIMONS:—In reply, I would thank Dr. Patterson and Dr. Royster for speaking to my paper.

In regard to Dr. Monsen's request, I would say that the bougie should be passed daily, and if the bougie is neglected the stricture will recontract. Precisely parallel conditions as stricture of the urethra, treated by dilatation. It is a trite old saying, "Once a stricture, always a stricture." If treated by dilatation only it will continue, unless treated from day to day. In this case that I discharged, if the boy fails to pass the bougie daily, as he was taught in the hospital,—if he passes that bougie every day he will be able to swallow. He could swallow before he left the hospital. I kept the stricture open because of the experience I had with the first operation, where the stricture was allowed to close from lack of attention.

As to the method of operation. I selected the Sabanajew-Frank method. Dr. Royster did Coder's method.

I was prepared, when I went into the operating room for that case, to take Coder's method. The advantage in that is it is unnecessary to pull the

stomach out of the abdomen to any extent, because the tube is imbedded in the wall of the stomach whilst it is well down in the abdominal cavity. For that reason Coder's method is particularly applicable to this case, in which the stomach was contracted and the surgeon unable to get the stomach out. But, when I got into the operating room, the house surgeon said to me, "You will have trouble; the stomach is so contracted you can't get into the wound." I was prepared to do Coder's, or some other operation suitable to a contracted stomach, but when I got there and inspected the abdomen of the man I found a previous incision had been made a little above the umbilicus and transverse to the rectus, and I was satisfied that what the house surgeon told me was correct, and that it was not the stomach, but that a portion of the intestines had been sewn. I concluded that Sabanajew-Frank's operation was an ideal operation,—and the result proved that was correct. Making an incision higher up, I put in my finger, and I could tell by the feel of it that I had the stomach, and I had no difficulty in getting out just as much as I wanted to get the cone necessary for the performance of the Sabanajew-Frank operation.

As to Dr. Patterson's remarks, I am glad he made them, because you will find that this concentrated lye is put up in cans, and so many little fellows drink it, thinking they have a can containing condensed milk. I have been teaching all of my patients the danger arising from these accidents, and asking them not to permit concentrated lye to be introduced into the house. I think the influence of this Association should be used, as he suggests, to try and have such legislation passed, as to the form, at least, in which it is put up, that it will be distinct, and the little ones will not mistake it for something else when it is in the house.

#### A PLEA FOR STATE SANATORIA FOR TUBERCULOUS PATIENTS.

BY J. L. DAWSON, M. D., LIBERTY, N. Y.

The universal fight that is now being made throughout this country against tuberculosis proves that the medical profession and the educated layman has at last realized that prevention plays as important a role as attempted cure. This disease, so widespread, and so far-reaching in its disastrous results, is undeniably curable when taken in hand early, and undeniably preventable. As medical men, we know that nature is the only source from which we can expect a cure. We have not yet discovered a specific, nor have we discovered immunizing agent, but we have discovered that if we are able to increase individual nutrition, to place the patient in a pure atmosphere and to educate him in the hygienic laws of life that

the majority of cases taken in hand early recover. We have also discovered that the disease is infectious, and that the infection being transmitted through the expectoration, is preventable; that inheritance is but a small factor in the production of tuberculosis, and were it possible to control every case the dread White Plague could be stamped out.

We have learned then, first, that tuberculosis is almost universal, and that a large majority of individuals over thirty years of age have some focus, latent or active, in some part of his body.

Second, that tuberculosis is infectious and communicable, and being infectious, is preventable.

Third, that as the majority of cases of tuberculosis get well, the disease is curable.

Fourth, that sufferers from pulmonary tuberculosis recover without change of climate, and that although climate is a factor in treatment it does not play the essential part it was once believed to do.

Fifth, that unhygienic surroundings, bad air, improper food, filthy habits, excesses in vice, over-crowding, etc., all tend towards the development and rapid progress of tuberculosis to a fatal termination.

Let us consider these facts seriously. The universality of the disease is not sufficiently recognized by our practitioners of medicine, and in consequence many cases progress to a stage too late for arrest, because the individual and his doctor are unsuspecting of the cause of the ailment. Early recognition of tuberculosis is essential if we expect to cure. Once lung tissue has been destroyed *en mass* and secondary infection with other germs has occurred the permanent cure is almost hopeless. How often do we hear people assert that because there has been no tuberculosis in their family, and no inheritance, that it is impossible for the symptoms they present to be tuberculosis. How often is the weak anaemic adolescent with dyspeptic symptoms and a slight cough doctored by the poly-pharmacist for months in the end to discover that he has an area of tubercular infiltration in the lung which has never been examined, and just here let me make a plea for the more

frequent and careful examination of the lungs. Physical diagnosis is extremely difficult, and our ears and eyes become trained only by constant practice. Slight changes in physical signs have to be carefully hunted for and recognized when found. Gross lesions that are manifest show themselves when too late to do good by treatment. How many of us neglect the thorough exploration of the chest and how few of us are able to recognize early and slight changes. How seldom do we conscientiously search for the tubercle bacillus in the sputum, whose presence clears up the doubtful diagnosis and makes the chain of vague symptoms point to the pathological lesion and cause. We must remember that we often discover the lesions in individuals who look "the picture of health," rosy-cheeked, stout, well-built people, often make us unsuspecting of the cause of their symptoms by their healthy appearance, and we are as apt to find the tubercular germ taking root and flourishing in the muscular athlete as in the anaemic school-girl. Upon the early recognition of the tubercular cause will depend our success in a cure or arrest of the process, and I again urge the necessity and value of more complete and thorough examination of every case that comes up for diagnosis.

That the disease is infectious and therefore preventable needs now no argument. The bacilli thrown off in the expectoration become dried dust and finds entrance through the respiratory tract of the exposed. Of late years this has become so well known that laws and ordinances are passed in every city making the act of spitting in public places an offense punishable by fine. But this is not enough. Patients themselves must be taught and made to understand the danger in their sputum. If the sanatoria established throughout this country have done no other good than to have taught their inmates to collect and destroy their expectoration they have accomplished a great point in preventative medicine. This is a point that we can not pass lightly. We must all do missionary work in this direction amongst our patients, especially those of the poorer and uneducated



classes. How little precaution is taken and how lightly the infectious nature of the disease is regarded is only too evident, and even in our hospitals, asylums and poor houses, directly under the care of medical men, the utter lack of precaution or careless attention to these matters is evident. We must awake to the realization of the danger from infection in tuberculosis, and the first step in the crusade against this disease, that claims its victims in such large numbers yearly in our midst, is to preach the fact that the expectoration is the cause of the spread of the germs, and to teach them how to destroy it and how not to contaminate their household and family, their friends and the general public.

As to the curability of incipient tuberculosis there is now no question. The records and statements of the Sanatoria throughout this country and Europe prove conclusively that the majority of early cases properly cared for get well. The Massachusetts State institution, at Rutland, claims 75% of cures in incipient cases during the last year, and every institution is yearly adding to its per cent. of cures. The treatment is extremely simple and the very nature of its simplicity renders it difficult of execution. Fresh air and outdoor life, with limited exercise and wholesome food; achieving the greatest amount of bodily nutrition whilst breathing a pure air are the only essential requisites. I have said that climate is not an important factor. It is only necessary that the air should be pure and not too damp, and that we should have a maximum of sunshine. To obtain these essentials it is only required that our consumptive leave the sea-coast and go into some country district removed from the crowding of cities and the vitiated atmosphere of factories and manufacturing towns. Having obtained this, the next step is the outdoor life. This should not be done in a vague, carnal way, but with regularity—the patient spending 15 to 20 hours out of the 24 in the open air. To accomplish this it is necessary that he sleep out of doors, for no matter how well ventilated a room may be or how many open windows furnish the air, experience has

taught that they do not do as well as when sleeping on an open porch or veranda. No matter what the weather or temperature, a tuberculous case can be taught to sleep out of doors and in a few weeks they themselves realize the benefits so thoroughly that they prefer it. The methods employed at the different sanatoriums and tuberculosis hospitals throughout the country is extremely interesting, and their magnificent results more than encouraging. At the Adirondack Cottage Sanatorium at Saranac Lake, N. Y., founded by the pioneer of the outdoor treatment of tuberculosis, Dr. Ed. L. Trudeau, the plan is to have cottages with four rooms surrounded by broad verandas. The door of each room opens on the veranda and is wide enough to permit the bed being rolled out and in. Each patient gets up at 7 a. m., has a cold shower bath or cold sponge as they prefer, dress and walk to a central building to breakfast. From breakfast until 11 a. m. he is out of doors, reading, playing games or carrying on any light occupation. From dinner until supper, 6 p. m., he is still out sitting on the veranda or strolling through the grounds. From 6 until 9:30 he is allowed to remain indoors. At 9:30 he prepares for bed; the bed is rolled out on the veranda, where he sleeps until morning. Now this is a very simple proposition in summer, but think of carrying out this routine through the winter, with the thermometer ranging from 20° below zero to 20° above in the 24 hours. The heavy snow fall makes walking out of the question and the intense cold interferes with usual pastimes; consequently these patients sit wrapped in furs and rugs for hours at a time using every method they can devise to keep warm. The beds are rolled into the warm rooms during the day so that they do not become chilled, and at the last moment before the lights are turned out they are rolled out on the veranda, the patients sleeping out of doors in this intense cold. The effect is marvellous; they become red checked and healthy looking, put on flesh, develop an appetite, feel well and cheerful, and soon see for themselves the benefits of what at first appears to them a cruel and

dangerous mode of life. At the Loomis Sanatorium Annex (where I have just passed the winter) they use lean-tos instead of cottages. They are cheap, easily taken care of, and give excellent results. A small central room which is well ventilated and heated, contains sixteen lockers or small closets, two tables and water basins, water closets, etc; from this central room a long veranda runs on each side capable of holding each eight beds. It is plainly built, covered with a shingle roof and enclosed at the back, the front being open; their width is sufficient to admit of a lounging or steamer chair to be placed at the foot of each bed. Here the patients sit during the day and sleep during the night, heavy canvas curtains on rollers in front of each bed protecting them somewhat from drifting snow and rain. I have often seen the beds covered with snow during the night, and each bed is provided with a rubber sheet to prevent the bed clothes from becoming damp. Patients are allowed to wear all the clothes they desire, and use any method that may suggest itself to them to keep warm at all times, only they are not allowed indoors between 7 a. m. and 5 p. m. except for meals.

In all these institutions great care is paid to the food and cooking. Milk and eggs are furnished freely and every one encouraged to drink milk between meals. Careful physical examinations of each case are made monthly and notes of each case kept. Weight, temperature and pulse are carefully recorded, and a minute history of the case is kept. The laboratory examinations of urine, sputum, etc., are made each month and a blood examination on admission and discharge. When cases develop some complications, as a hemorrhage for instance, there are rooms in the main building used as an infirmary, or in the larger institutions a thoroughly equipped small hospital is a part of the institution. The curative process in tuberculosis is necessarily slow and covers a period of years in many cases. The length of stay in the institution of course varies usually from six months to one year. During this period the general

conditions of the individual is greatly benefited, but this is only a small part of the good accomplished; he is taught how to live and how to take care of himself, and he is taught how each case is a specific focus of infection and how he must avoid conveying the disease to others. When the whole civilized world is educated up to this point we will find tuberculosis decrease the number of its victims each year and finally this widespread infection may be stamped out. Why is not the care and treatment of tuberculous patients taken up and managed by the State Governments? Gradually the different States in the union are beginning to see this matter from the right standpoint and building and maintaining their institutions. They will care for and battle with yellow fever and small pox patients when these diseases kill only an infinitesimal number compared with tuberculosis, and yet they allow this infection to exist broadcast and take no steps towards its prevention and cure. As the disease is met with most often in the poor, badly fed and uneducated, it behooves the authorities to look into the methods of life of these people and when the disease is found amongst them they should be removed and cared for. Numbers of the State institutions are run on a semi-charitable basis. Patients are charged on the average of \$5.00 a week in most of them, and the State supplies the deficiency. With an appropriation for the original plant and a small charge for each patient, the annual expenses need be small.

The State of South Carolina is provided by nature with a climate peculiarly adapted to the treatment of tuberculosis. The short, mild winter would make the cost of a State institution much less than those of the Northern and Western States. The death rate from this disease is enormous in our State and on the increase. I have not been able to procure the figures for the State, but in the City of Charleston I find that in 1903, 217 persons died of tuberculosis or 3.87 per 1,000 of population, and that in the decade ending 1903, 2,590 deaths are recorded from this disease. Now if this Association could memorialize the legislature and get



them to appropriate a sum for an institution, and run it on approved methods, economically and efficiently, they would be able to save many valuable lives and at the same time, by removing foci of infection from populous districts, so diminish the spread of the disease. Elaborate institutions are not necessary. The plan of lean-tos at the Annex of the Loomis Sanatorium are cheap and perfectly efficient. There is no need here in this sketchy outline to go into figures of expenses, but suffice it to say that these buildings can be erected at a cost of about \$100 per patient. Of course this is exclusive of executive buildings, furnishings, site, etc., but in our mild climate the outdoor life could be thoroughly carried out and at the same time light and useful employment given patients, which would reduce the cost of living, such as growing the necessary vegetables for the table, raising poultry and eggs, running a model dairy farm, etc., all of which are perfectly feasible in conjunction with a State sanatorium for tuberculosis. This paper is a mere suggestion to the State Association to consider the matter and discuss its practicability; and having lived and worked in two of the best known institutions in this country for the past year, I have become impressed with the importance of the war against the Great White Plague and its management and control through institutions and sanatoriums.

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**CLINICAL PRESENTATION: A CASE OF  
COMPLETE DOUBLE CONGENI-  
TAL CAPSULAR CATARACT.**

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J. W. JERVEY, M. D., GREENVILLE, S. C.

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Professor Herman Knapp relates the following incident which occurred during the incumbency of his Heidelberg clinic: "A poor widow brought to me her twelve year old daughter, who, she said, had never had any inflammation or disease of her eyes, but was born blind. I found both pupils narrow and closed

by a pseudo-membrane. One eye showed signs of irido-choroiditis, was shrunken, and totally blind. The other, however, was well formed and had good perception of light. My diagnosis was congenital blindness from foetal irido-choroiditis. I admitted her to the clinic, and on one eye made an iridectomy which gave her good sight. The case was presented and analyzed before the students as remarkable and important in its embryological and practical aspects. She left the hospital in a week.

"Two weeks later the secular press was full of high-colored accounts of the 'wonderful restoration of sight in a blind-born twelve-year-old girl by the Holy Virgin of Walldurn,' the Lourdes of the Catholic portion of the Grand Duchy of Baden. The wonder was attested by the priest, the physician, and the mayor of the place, and by a Spanish Count. The incident was true, the story went, and the wonder so much the greater as the child had been admitted to the Eye Clinic at the University of Heidelberg and after short treatment discharged as incurable. As soon as I had read the story I informed the priest of the facts. The report had been so widely circulated that a high official of the government sent me a letter of inquiry in regard to what I knew about the case. I answered that I had written to the priest at once, but had not received a reply. I had abstained from a public refutation because I believed the priest to be a benevolent, honest man, for he had sent to the University Clinic many eye patients that had gone to Walldurn. The government official wrote me back: 'You will receive your justification, but you will have to wait two weeks. The place requires a wonder every few years to keep up its reputation.' So it was. The priest thanked me that I had undeceived them, and in excuse for the delay of his answer he said the child had been presented to them as congenitally blind, and had behaved so, but after she had been led to the church several times, and then held over the altar of the Holy Virgin, she had exclaimed, 'I see, I see!' In order to explain the undeniable fact of the child's sight they had written to the mayor of

the birthplace of the child, and had not received an early reply."

I have had the good fortune to see a case here, that is in some respects similar. This small boy, whom I present to you for inspection, was brought to my office last summer. He is 12 years old, and for the past two years has been at the Cedar Springs Institute, the State Institution for the Deaf, Dumb and Blind. The only vision he had was that in the right eye. He could distinguish brilliant colors if brought within an inch or two of his face. Merely a little corner of the pupillary opening permitted any vision at all—at best only a fleetin<sup>g</sup> glance—and of course he had no practical sight. I found he had double congenital capsular cataract, and advised operation. Owing to the fact that he had not seen during his lifetime, the eye-balls, as you will observe, are very small, have never been fully developed—although this is partially hereditary, other members of the family, the mother markedly, having small eye-balls. From the fact that he has never seen, he has no co-ordination of the ocular musculature; he cannot fix his eyes on anything; sees more than he knows he sees; does not realize what he does see; in fact, he will put out his hand now, thinking he can touch something that may be 20 feet off. With a plus 9 spherical lens over each eye he has now an actual vision of about  $\frac{10}{100}$ . That is perfectly practical sight for entering any one of the coarser trades. Of course he could not do any work that requires close application of the eyes, but he is at least so much better that he can follow any of the coarse arts or trades with perfect satisfaction. The case is more or less pathetic, as he is the only boy in a family of five.

The operation I did was extremely simple, requiring no skill particularly. Almost anybody could put a needle into the eye and break up the capsule, although it is almost always necessary to repeat the operation.

In this case I operated first on the right eye. I thought it wise to go slowly and cautiously. The capsule was thick, tough, and leathery, and I found in a few weeks

that I had to repeat the operation. I repeated it on the right eye, a simple dissection, three times, and I have not especially good results in that eye. The capsule is too tough; it breaks up, but owing to the elasticity of the fibres it has a tendency to draw, and I cannot cut it across the fibres. I am going to complete the operation by making a linear incision along the cornea and snipping off that capsule with scissors.

The left eye I operated on about two weeks ago. Having gained a certain amount of vision in the right eye, I considered I could justifiably do more radical work in the left without waiting for the slow process. He is a very nervous child. I performed the operation with chloroform anaesthesia, making the usual corneal incision, hooked the pupillary margin with a blunt hook, drew it out and made the iridectomy, and then, with forceps, grasped the capsule, drew it out and excised it. This eye, as you will observe, is by far the best of the two, though only operated on two weeks ago, and only once. He has now good practical vision, and in time he will learn to appreciate distances and get good judgment of projection. I am inclined to think, too, that more or less muscular correlation of the two eyes will become established later.

(Case presented and examined by members.)

DR. HORLBECK: This is a very interesting subject to any man who has done eye work. I have looked at the case, and think the doctor is to be congratulated on it. As the doctor says, it is not a difficult operation, but it is one that is very delicate, and requires a good deal of judgment. Unfortunately, there are a great many of such cases around. Since I have been practicing in Columbia I have been fortunate enough to see two such cases, but for religious reasons they refused operation, thinking the affliction was put there by The Almighty and ought to stay there.

These operations require a great deal of judgment in regard to time to operate, and, after the incision is made, in watching the eye in regard to tension. Dr. Jervy says that the tension was not increased in the eye after operation,—I presume, due, as he says, to almost complete absence of lens matter in each eye,—a slight amount of degenerated lens matter in each. I think the more suitable operation was done on the left eye, taking out the capsule, because undoubtedly the trouble with the other eye was a thickening of the lens capsule itself.

DR. PORCHER: I want to offer the doctor my congratulations; first, on his pluck in attempting to



remove such a condition as that, and next on his success in doing it. I think the man who operates on a case like that, with his reputation at stake, deserves the thanks of the Association for undertaking it.

DR. MONSEN: I congratulate the doctor on his success, and thank him for the initiation in undertaking the work. It will move some of us to do more careful work and not think that the large operations are the most essential.

DR. JERVEY: I thank you, gentlemen, for your very kind reception of the case, and for the privilege of presenting it.

## ANEURISMS OF THE GROIN.

### Report of a Case.

A. J. BUIST, M. D., CHARLESTON, S. C.

The infrequency with which we see aneurisms of the groin and the comparatively high per cent. of failures observed in their treatment are my excuses for this report of a case operated upon in December, 1904.

The case was that of a negro, age 43, occupation wagon-driver, who entered the City Hospital, Charleston, S. C., December 23rd, 1904, suffering from intense pain in the left groin, numbness of the inner side of the thigh and inability to walk or stand. A tumor about the size of a hickory nut had been noticed first by the patient in August, 1904, just beneath Poupart's ligament. Its growth had been slow but continuous. Upon examination there was found in the upper portion of Scarper's triangle and extending upward and beneath Poupart's ligament a pulsating tumor, globular in shape and about the size of the fist. The pulsation was expansive and there was present a thrill and bruit. The skin over the tumor was tense, glazed and hot and upon palpation deep seated fluctuation was felt. The patient's pulse was 126 and temperature 99 3-5. A diagnosis of aneurism of the common femoral and lower portion of the external iliac arteries accompanied by inflammation of the sac and perivascular tissues was made.

Because of the thinness of the coverings of the tumor all other forms of treatment were inadvisable and operation was suggested and performed Dec. 29th.

As it was uncertain how far up the external iliac artery the disease extended the extraperitoneal method of ligating that vessel was deemed inadvisable and the transperitoneal method of operation employed. The bladder and rectum having been thoroughly emptied just prior to operation, the abdomen was opened by a median incision, the patient placed in the Trendelenburg position, the intestines held back by pads and the bladder held well forward. In this way the iliac vessels can be easily examined by the eye and finger and the height to which the disease extends can be readily observed. It was seen that but the lower portion of the vessel was involved and that a ligature could be easily and safely applied to the middle portion of the vessel at the most desirable point. An incision three-quarters of an inch in length was made in the peritoneum overlying the vessel, the artery separated from the vein and a No. 2 chromicised cat gut ligature used for ligation. The peritoneum was now brought together over the vessel and the abdominal cavity closed in the usual way. Examination of the aneurismal tumor now showed that it was slightly smaller, and that pulsation and bruit had ceased. The limb was wrapped in cotton, elevated and artificial heat applied for a few days. The temperature remained above normal for several days and the pulse rapid for about two weeks, but the pain in the groin rapidly disappeared. The collateral circulation was quickly established, the nutrition of the limb never being threatened. The tumor continued to diminish in size, the patient got out of bed on the twenty-first day after the operation and left the hospital on January 27th. He was seen in the latter part of March, at which time he complained only of a sensation of numbness over the inner portion of the thigh.

He was again back at work in the capacity of a porter. The tumor at that time was hard, non-pulsating and about one-fourth its original size.

From a perusal of even the most recent works upon surgery we are left somewhat in doubt as to the best method of treating aneurisms of the larger vessels. The

statistics found therein would lead us to believe that the mortality and failures resultant upon ligation of the external iliac artery for aneurism of the groin are high. These statistics were, however, for the most part, compiled prior to the attainment of the perfect asepsis that we have in operation to-day.

Delbet's Statistics, published in 1889, comprising the results of sixty-seven cases in which the external iliac was ligated for aneurism of the groin show 42 cures and 25 failures, 13 of the failures resulting in death, a mortality of 16.9 per cent. Kirmisson's group of 40 cases reported in 1884, show a mortality of 12.5 per cent. As late as 1898 Morton collected 29 cases of aneurism involving the iliac artery, in all of which ligation by the transperitoneal method was adopted, in which there were 22 recoveries and 7 deaths. A number of individual cases reported since that time, however, seems to indicate that the mortality is much less.

Dennis, in 1886, was the first to suggest the transperitoneal method of ligating the common or external iliac artery for all aneurisms of the groin. This is undoubtedly the simpler and safer operation, especially if the tumor seems to extend above Poupart's ligament. There are many advantages which it has over the extraperitoneal method. In the first place, it is the easier of the two operations. All that is necessary is to see that the rectum and bladder are thoroughly emptied just prior to the operation, and that by means of the Trendelenburg position and pads, the intestines are held out of the way.

By these procedures the pelvic cavity is rendered practically empty, both the external and common iliac arteries can be examined by means of the eye and finger, the extent to which the disease extends up the artery noted and the ligature can be applied in the most advantageous position. There is little or no damage done to the cellular tissue surrounding the iliac vein. The position of the ureter must be remembered and care taken that it is not included in the ligature. The extraperitoneal operation is much more difficult. In its performance we are more than apt to injure

the deep epigastric and deep circumflex arteries, the integrity of which it is important to preserve. The spermatic vessels, the ureter, if it crosses the artery low down, the genital branch of the genitocrural nerve, the spermatic cord and in the female the ovarian vessels must also be avoided. Pelvic cellulitis and peritonitis have not infrequently followed the more or less rough handling of the subperitoneal tissue in the attempt to shove the peritoneum upward and out of the way. Again, the handling and damage done to the sheath of and cellular tissue surrounding the iliac vessels is much greater than in the transperitoneal operation, a fact that increases the possibility of a phlebitis of the iliac vein with its resultant interference with the return circulation from the limb.

The chief dangers incident to the operation are secondary hemorrhage and gangrene. The first is best avoided by strict asepsis, it being rarely seen if the operation is a clean one. Gangrene may be due to too slow development of the collateral circulation or to the occurrence of an iliac phlebitis. The importance of preserving the deep epigastric and deep circumflex iliac vessels is apparent. Not only do they assist materially in maintaining the circulation in the limb, but because of their allowing a certain amount of blood to flow through the iliac and femoral arteries below the ligature there is enhanced the formation of an active clot in the aneurism which upon becoming organized perfects a cure. The cutting of these vessels at the time of ligating the iliac artery occasions the formation of a passive or soft clot which may excite inflammation and suppuration in the sac with subsequent rupture. Circulation in the limb should be encouraged by elevation, wrapping with cotton and the judicious application of artificial heat.

Phlebitis is best avoided by the use of a non-irritating absorbable ligature and little interference with the vein and its cellular sheath.

Among the subsequent and lesser evils resulting from the operation are permanent deterioration of the nutrition of the



limb, loss of nerve or muscular power, and persistent and recurrent ulceration of the skin.

The question of incision or excision of the sac and contents necessarily arises in these cases. The results following those cases in which it has been done lead us to believe it is not the best operation. At any rate nothing is gained by excision at the time of ligating the iliac and much may be lost as the chances of gangrene are increased and there is danger of injury of the femoral vein. Subsequently if suppuration in the sac takes place or pulsation in the tumor recurs and is persistent, excision may be done with ligation of the vessels entering the sac. By this time the collateral circulation has had time to become better established.

Other methods of treatment of aneurisms in this locality have been attempted, such as galvano-puncture, compression, forced flexion of the limb on the body and the injection of coagulating substances but they have with few exceptions resulted in failure. Spontaneous cure of aneurism of the groin is very rare and the best chances of success seem to follow ligation of the external iliac by the transperitoneal method.

#### DISCUSSION.

DR. M. SIMONS: This is too valuable a contribution to allow it to pass without discussion, and I would ask Dr. Royster to speak on the subject. I am interested in the case, because I saw it with Dr. Buist. He got a brilliant result, and it was altogether a brilliant operation. The ease with which that artery was tied was something that is very attractive. To a man familiar with abdominal work, and who knows how to get into the abdominal cavity, the ligation of that artery was easy, and when the doctor got through with it, the wound, was scarcely appreciable. I was particularly interested. I had had a similar case, and had never seen an artery tied in that way. I did a much more difficult operation, taking out the whole sac,—a very desperate operation,—and was anxious to see what this operation would produce, it gave me great pleasure to see the ease and skill with which it was done.

DR. ROYSTER: I feel very much as if I shall need Dr. Porcher's treatment before I get through, and I should not have thought of rising to speak on this subject except having been asked to do so.

I think this is one of the best papers I have heard at this meeting, for two reasons: first, it shows what can be done by proper diagnosis and treatment, and second, by a proper description of it after it is done. It is very seldom that a

man can do both equally well. I think the doctor is to be congratulated on his handling of the case.

The diagnosis for aneurism is usually easy; sometimes it fails. I knew a country doctor in my State some years ago, a very brilliant surgeon, who was a loss to the surgical science because he did not report any of his cases. He said he was driving along a road one evening, with his eyes shut, when a man jumped out of the woods and hailed him, and said, "Doctor, I have a little tumor, or a little rising in my knee; I wish you would cut it." The doctor said all right, and put his lance into it, and the blood spurted. He said that he took him to a nearby branch and got a flat stone and bound it on the wound with a strip from his shirt, and carried him home. "And," he said to me, "do you know, that darned fellow got well."

Dr. Buist's paper shows they can not only get well under those circumstances, but it is best to give them a chance in the right way, making the diagnosis and the operation in the right way.

I have had three cases, with good results.

One had a disturbance of the skin, and another disturbance of circulation, owing to the fact that the patient had tertiary syphilis, and these manifestations continued for some months.

This operation which the doctor did was just the right thing, done in the right way, and the result is sure to be right. I agree with him entirely in his ideas of excision of the sac, and his reasons for not excising it were stated perfectly. It makes an otherwise easy operation dangerous and difficult,—I say easy, when planned properly,—it adds to the danger and does nothing to help the result. He had confidence in himself, and faith that he was doing the right thing. I think these operations ought all to be reported and discussed.

DR. BUIST: I thank the gentlemen for the remarks made concerning the paper. There is nothing more I can add to it.

I have on three occasions tied the femoral artery, but this was my first experience with the external iliac. I tied one for aneurism in the femoral lower down, in which there was a recovery. I tied the artery again, in a case Dr. Whaley operated on for some trouble in the popliteal space, whether an aneurism I do not know. The man had a secondary hemorrhage. Dr. Whaley had turned the case over to me then, and I ligated the femoral in its lower portion.

That man recovered. I ligated the artery the third time for gun-shot wound in the artery. In all three cases there was no evidence of any interference with the circulation.

#### SUPPURATING APPENDICITIS.

BY F. L. POTTS, SPARTANBURG, S. C.

Mr. President and Gentlemen:—

I have chosen for the subject of this paper "Suppurating Appendicitis,"—a subject I know that is well worn, but one still interesting and most important, and

I may also add, a condition that should be prevented to a greater extent than at present. I claim no originality whatever in presenting to you a few well established facts, facts that are worth much, facts if well taken and heeded will save a great many precious lives, lives that are being lost by the so-called medical treatment instituted at the beginning and kept up two, three or four days, before surgical interference is thought of; this I claim is the cause of our mortality in appendicitis, in as much as it is the cause of suppurating appendicitis. Appendicitis is pre-eminently the disease attended with pain and tenderness in the right iliac fossa. Whatever the immediate cause, whether it be a quickly acting one, or, as is most common, has been silently working, the attack itself is generally sudden, and announces itself by acute abdominal pains, by tenderness in the right iliac fossa, by nausea and vomiting. The pain and tenderness are very significant. Although a continuously improving technique, has within the last few years considerably reduced the mortality after operations for appendicitis, the problem of successfully coping with suppurative and infected cases is still far from being solved. The vigorous stand taken by most operators in favor of early operation has borne fruit. The doctrine that the best results in all cases may be obtained by an operation as soon as the diagnosis is made, gains ground daily, and would, if generally accepted, make the subject of this paper unnecessary. But, as long as through fault of the patient, or of the medical attendant, cases are allowed to progress to suppuration or gangrene, so long will the operative treatment be restricted in its beneficial results, and have failures to reckon with, from peritonitis, and from septicaemia. Should the operation have been performed in the "Appendicitis Stage" of the disease, the mortality would practically be nil. The germ of putrefaction ever present in an important state within us have been afforded an opportunity to develop, over a small or greater area of the appendix. A cut off circulation constricting bands, swelling and pressure against a fecal concretion within are

the causes which so alter the tissues of the appendix as to remove from it all vital resistance and allow putrefactive germs to develop, as in the body after death. The irritation in the neighborhood is, in the majority of cases, sufficiently great for adhesions to have formed. The tip of the appendix, its base, its middle portion may partake in the abscess formation offering the particular spot undergoing gangrene, as a part of the abscess wall. The rest of the abscess wall is formed by knuckles of intestines in its immediate neighborhood. The appendix may point in any direction and may have hidden itself in any conceivable way between the caput coli and ilium. Temperature and pulse are unreliable indications of the gravity of the condition. The mixed infection may make the process slower, establishing a firmer or less firm fibrous isolating membrane, rupturing less easily or not, and regulating the possibility of disseminative peritonitis: This is a condition open to the most varying procedures. To ascertain absolutely whether the peritoneum is infected or simply irritated, whether irrigation should be resorted to or not, whether drainage of the abdomen should be closed, or the abscess region packed and the wound left open: If septicaemia be not already present, the judicious selection of one of the above methods of treatment establishes the difference between success and failure. It is difficult to establish at sight the difference between a violent irritation of the surrounding peritoneum, and a disseminated infection from the abscess. The formation of lymph membranes tending to agglutinate the neighboring knuckles of gut is an index of mere irritation by transuding toxins. This is not alarming and is but further and extended effort of nature to isolate the diseased parts. Not so, however, when the surrounding intestines are red, angry and distended, without adhesions. Here a genuine peritonitis extending from the abscess exists. It is caused by the germs themselves from the original focus of disease, and is a fair indication that the abscess wall has yielded, be it ever so little. In this case there is a certain amount of serous fluid,



free in the peritoneal cavity, although the inflamed area be limited to the intestinal knuckles in the immediate neighborhood of the abscess. In the cases denoted as abscess with surrounding irritation, the operative procedure indicated is the following: Isolate the abscess before opening, by surrounding it with large gauze pads, and thus protect the rest of the abdominal region from possible contamination, seek the appendix, extricate it from its adhesions, remove the pus by sponging, amputate the appendix: Scrape the abscess cavity gently with gauze: clean it further with hydrogen peroxide. The cavity is now packed with iodoform gauze, the original isolating pads removed, fresh ones substituted and the wound left open to granulate. A large amount of gauze is placed on the surface for absorption of drainage. This surface dressing should be changed every six hours during the first forty-eight hours. Under no circumstances should the packing be disturbed in less than forty-eight hours for fear of destroying the adhesions we hope to build. They may, however, remain much longer. At the end of this time, adhesions have sufficiently formed to enable us to remove the packing, as well as the isolating pads. The case will be treated subsequently by simply packing the seat of the abscess. This may be renewed every second day until granulations have finally filled the wound. Quite different indeed is the course to be pursued when a genuine local peritoneal inflammation exists with semi-purulent fluid free in the peritoneal cavity. The procedure just described fails absolutely here, and the disseminating peritonitis continues its course until a fatal termination. I have seen at *post mortem* the local seat of the abscess in a comparatively healthy condition while a general peritonitis extending from it has been the cause of death. Since this is the case we must reckon this particular condition in the same class as those of general peritonitis. In other words, general peritonitis, as we find it at operation, was at one moment in this same condition, and is only greater in degree and must be treated as such. The treatment of general peritonitis, is the same to-day,

whatever be the infecting organism. The disease now to be treated is no longer appendicitis. The problem is to destroy the living germs which have invaded the whole surface of the peritonem, using the serum of their membrane as their culture food. Here nothing short of complete evacuation with careful irrigation of the whole abdominal cavity will suffice. Irrigation must be prolonged to the greatest extent endurable by the vital condition of the patient. Warm sterile water is the preferable irrigation fluid at a temperature, 102. In aggravated cases, I have seen irrigation continued after the patient has been returned to bed. With a large trocar an opening was made through the abdominal cavity in the right and left hypochondriac region. A large rubber tube about six inches long was passed through these openings. When the abdomen was sutured a similar rubber tube was placed at the superior and inferior extremity of the wound, making four tubes penetrating the abdominal cavity. The irrigating apparatus was connected with each of these tubes in turn. Irrigation was used every two hours in the first forty-eight. This mode of irrigation offers, I believe, the most prospect of checking by local means, a general infection of the peritoneum. Should, however, toxæmia exist, it is a separate disease, as it were, added to the appendicitis and peritonitis, and demanding treatment specially directed to it—death can result from toxæmia even though the peritonitis be improving or cured. this fact is illustrated by tetanus, though a local disease at first, subsequently becomes constitutional. We may resort to amputation of the infected limb, but even this would not suffice to check the fatal course of the infection beyond. Saline hypodermoclysis has been used with perhaps better results than any other remedies. Practically we are here limited to tonics and stimulants, a poor substitute, indeed, for a direct anti-toxin. These cases usually proceed to a fatal termination. A careful analysis of deaths due to appendicitis, or rather conditions caused by neglected appendicitis should help us to establish that appendicitis itself is not the terrible condition it is

thought to be: that the unfortunate sequelae, peritonitis and toxæmia, are the truly dangerous conditions, which an expectant, or medical treatment has allowed to exist. These two conditions present therapeutic problems that are still unsolved. The surgical treatment of appendicitis proper is almost ideally perfect, and practically free from danger. Let us labor to impress these facts upon the profession at large, and the laity. Let us teach and practice so that no case ever goes beyond the stage of pure appendicitis, and insist that no medical man be excused from letting this precious stage pass by.

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### GANGRENOUS STOMATITIS.

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BY WILLIAM A. SMITH, M. D.,  
GLENDALE, S. C.\*

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This is a gangrenous process which usually begins upon the gums or inside of cheek, spreads very rapidly and usually terminates fatally; it is, fortunately, a rare disease. Various causes have been given for the gangrenous process in this disease, which I will not mention, more than to say it occurs more frequently as a complication of measles, but sometimes follows other exhausting diseases of infancy and childhood. The gangrenous process of Gangrenous Stomatitis being usually a secondary disease, the process is one of rapidly spreading gangrene, in most cases there are thrown out inflammatory products in quite large quantities with little or no tendency to limitation of the disease. This usually advances steadily until death occurs. In a small number of cases a line of demarcation finally forms and the slough separates, leaving a large area to be filled in by granulations and cicatrization. The general symptoms are those of profound prostration and sepsis, temperature is generally from 101 to 104; of the local symptoms, often the first to attract attention is the odor of the breath, or, sometimes, the dusky spot on cheek or lip; on examination of mouth

there is usually found upon the gums or inside of cheek a dark, greenish black mass, surrounded by tissues which are swollen and oedematous; externally, the parts are tense and brawny, from the swelling, this infiltration always extending for some distance beyond the gangrenous part; as the process extends, the teeth loosen and fall out, there may be necrosis of the alveolar process of jaw and perforation of one or both cheeks or lower lip,—extensive sloughing takes place in one or both sides, giving the patient a horrible appearance. The odor is very offensive, and, in spite of all our efforts at disinfection, the odor fills the house. Pain is rarely severe, and often absent; extensive hemorrhage is rare.

The text books say Gangrenous Stomatitis is more common in females than males. In May and June, 1892, there were three cases at Glendale, S. C., all males. Two of these cases I saw, one of which I had the misfortune to attend. The first one I only saw by chance—the family physician asking me to see it through idle curiosity,—the child I would say was about eight years old and in the advanced stage. The clinical history was that child's previous health had been good; had recovered from measles about ten days before and complained of sore mouth, which was paid little attention to by parents; asked the family physician to call and see the child, this he did and left a simple prescription, stating that child would be all right in two or three days, if not they could notify him. The following day physician was again called, and, to his astonishment, found two teeth ready to fall out, the gangrenous process continued till the entire face sloughed off above the supra orbital ridges, presenting the most ghastly appearance.

The next one was the unfortunate one that fell into my hands: On June 3, 1892, Mr. B—— asked me to call and see his boy, a child about 6½ years old, suffering from diarrhoea, which I did, and found the child had had fifteen stools in twelve hours; temperature 101, with the most offensive breath I ever smelt in my life. I examined mouth and found a gangrenous mass on left inferior maxilla

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\*Read before Spartanburg Co. Med. Soc., July 28, 1905.



and a hole about the size of a five-cent piece nearly through the left cheek, about one inch from corner of mouth, and the following two days the slough had extended through the corner of mouth. The process continued until the entire left cheek sloughed out to a line of demarcation just beyond the angle of jaw, presenting a very horrible appearance. Treatment—text books recommend actual cautery after cutting away diseased parts or nitric acid, acid nitrate of mercury, peroxide hydrogen and curetting. In this case I used nitric acid twice daily and packed cavity with carbolized cotton, and later used Monsels' Sol., and packed as before. I gave a mixture of R. Tr. Iron, Chlo. Pot. Quin. and water. In three or four days after the iron mixture was given, the diarrhea ceased and child's appetite was good throughout entire course of disease. The remarkable feature was the child recovered and is still living, being able to open mouth about  $\frac{1}{8}$  of an inch. I removed with a pair of artery forceps about two inches of alveolar process of inferior maxilla.

Gentlemen, this case was treated by me purely on my own judgment, as in no text book I had at that time could I find anything I thought would give me any idea as to diagnosis, nor did I ever know until I saw a picture in Holt's book on diseases of children, 1898, that confirmed in my mind the proper diagnosis.

I hope the Spartanburg County Medical Association will overlook the shortcomings of this paper, it being the first I ever attempted to write, and cases reported being from memory, as I kept no notes, and occurred thirteen years and two months ago. I thank you very much for your attention.

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#### ENTEROCOLITIS, OR SUMMER DIARRHOEA OF CHILDREN.\*

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J. L. JEFFRIES, SPARTANBURG, S. C.

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Enterocolitis of infancy and early childhood may be considered to embrace all forms of summer diarrhoea from the

loose alvine discharges due to indigestion and fermentation to the bloody mucous discharges of dysentery caused as we are now reasonably certain by a specific bacillus. From recent investigations of summer-diarrhoea from the standpoint of the bacteriologist we have learned that there is no uniform clinical picture presented but that the cases whose stools contain the specific bacillus includes all the varieties of illness that are commonly included under the head of Summer Diarrhoea. One authority divides or rather suggests a division of the cases in which the bacillus is found into two groups, *viz.*, the toxic group, which presents itself in varying degrees of severity, from the milder types of gastro-intestinal disorders to the types of profound poisoning resembling and often mistaken for cholera infantum. In this group, as in cholera infantum, the chief symptoms are apparently due to the absorption of toxins from the intestinal tract. The other group represented by those cases which show daily remissions of temperature with blood and mucous in the stools and occurring in varying degrees of severity is familiarly known as Dysentery.

This disease usually prevails at such times of the year when for several days and nights in succession the atmospheric temperature does not fall below 60 F., notably during the latter part of May, throughout June and July and to a less extent during August, by reason it is supposed of the longer and cooler nights of that month.

Cholera infantum as a type of summer diarrhoea occurring alone or as a complication of enterocolitis is deserving of special mention, for the reason that its primary cause is different from that of enterocolitis and the character and severity of its symptoms are for the most part very widely different from those of enterocolitis. Cholera infantum presents us with a clinical picture distinctly its own, and as such should be ever before our minds when called to the bedside of an infant suffering with very high temperature, extreme restlessness, constant nausea and vomiting, with frequent copious and thin watery stools.

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\*Read before Spartanburg Co. Medical Society, May, 1905.

With this brief mention of cholera infantum I should leave the subject and resume the subject of enterocolitis, with special reference to its dietetic management and medical treatment, presuming that all of us are familiar with its symptoms and diagnosis.

We are called to a child, say six months old, nursing a healthy mother, perhaps being fed other food besides the breast milk. Nausea, vomiting, with temperature and tenesmus coming on suddenly have made the Doctor's visit necessary, or the mere fact of the bowels moving too often the Doctor has been called in. If the child seems much sick we immediately empty the rectum and lower bowels with warm water enemata, just as in an ordinary case of indigestion in which this form of diarrhoea often finds its origin. The lower bowel emptied by the enemata pain and tenesmus for the time being relieved we order one-fourth grain of calomel and soda, repeated every hour until we have given three-fourths to one and one-half grains each, and then after a variable interval administer a dose of castor oil. This simple but effective treatment usually ends the trouble, even when the child is immediately put back to the breast, which should be withheld until ten or twelve hours have elapsed, in order to allow the stomach and bowel to be well cleared of all irritation before imposing other tasks upon it. If with this care and treatment of the breast-fed baby the bowels continue too loose and too frequent, a little bismuth and chalk mixture with some alkaline diuretic, either of ammonium or potassium (I am partial to potassium citrate in some palatable form) will soon restore the normal equilibrium and the child is well again.

These salts of ammonium and potassium are in my judgment very valuable aids, both as eliminants, diuretics and diaphoretics, and antipyretics, and certainly are far safer than any of the coal tar preparations.

There can be no doubt that the healthy breast milk has aided us very materially in our success in effecting so prompt a recovery. The nursing baby has a resisting power that the artificially fed baby does

not possess, and we should never, unless the indications are very plain to the contrary, deprive a sick baby of a healthy mother's milk. If from fatigue, both physical and mental, the mother seems to nourish her child poorly, do not be too hasty in concluding that the breast milk is disagreeing with the baby, but seek first the cause in the mother, impress upon her the importance of taking sufficient sleep and suitable recreation, as well as giving proper attention to her diet and the condition of her bowels, and hold on to the breast milk and you will find the sick baby recovering where others deprived of it do not. We know that healthy nursing babies are peculiarly immune to the contagious and infectious diseases. The second summer, so much dreaded by mothers, only emphasizes the fact that the child totally or partially deprived of the breast and being fed on artificial and other kinds of food, its vital powers being lowered thereby, becomes the easy prey of stomach and bowel disorders. Breast milk then is our safest article of food, and our best means of prophylaxis when we are called on to treat a baby sick from any cause whatsoever, and especially when it is suffering from enterocolitis.

When called to the case of a child with enterocolitis who has been weaned or who for some reason has been artificially fed from birth, we have a decidedly more difficult problem to solve. Our initial steps in treating the case are about the same as in the case we have just mentioned. At first withholding all food for a time until we can get our calomel and oil to act, using nothing in the stomach except plain water sterilized and cooled, not ice water, and in quantities sufficient to satisfy thirst. The length of time necessary to withhold food varies with the intensity of the symptoms and the individual child. In my judgment we err more often in resuming food too soon—forty-eight to sixty hours may not be too long to withhold it. When we feel safe to begin feeding it is best, I believe, to withhold all milk and food preparations prepared of milk, and the artificial foods found on the market, or even the latter alone by reason of the excess of sugars



in their composition, and begin with small quantities of some one of the dextrinized gruels or rather some one of the cereal gruels, whether dextrinized or not, which time out of mind have served a good purpose for the sick. To Dr. Chapin, of New York, we are indebted for the discovery of a diastase made from malted barley which so modifies the cereal gruels that the resulting dextrinized gruel becomes as fluid as water, the insoluble starch being converted into dextrin and maltose, which are freely soluble in water and hence are made far more easily digested and assimilated than the crude starch of the gruel. These gruels alone or dextrinized are sufficient to sustain life. Mother's milk contains within normal limits 3 to 5% of fats, 1 to 2% of proteids, 6 to 7% of sugar and 0.2% to 0.3% of mineral matter. In the words of Chapin, "Cereals, like all foods, contain fats, proteids, carbohydrates, mineral matter and water." The dextrinized gruels containing as high as 3% proteids and 12% carbohydrates are rendered soluble by the dextrinizing process and thus are made almost perfectly assimilable. The dextrinizing process had been worked out by Dr. Chapin prior to 1904, but on account of the difficulties to be overcome in preparing and preserving the diastase it could not be put into practical use. Thanks to the Chemists who have overcome these difficulties and have given us a stable glycerite of Chapin's diastase known on the market as "Cereo," any druggist can obtain it for us ready for immediate use. One teaspoonful to half pint of barley gruel will completely thin the gruel in a very short time and thus prepared it may be seasoned with salt or sugar, or both, and fed to the sick child, either alone or as a diluent of egg albumen or milk when milk is readmitted to the dietary.

As valuable adjuvants in feeding we have at our command the meat juices, extracts, teas, broths, all of which are worth our consideration. They are good appetizers, and have some nutritive value. The liquid beef peptonoids are useful especially when the case is continued with emaciation and with high temperature, indicat-

ing inflammation and ulceration of the bowels. How much nutrient value is contained in the peptonoid preparations, per se, I do not know, but there is some, and in addition to this there is a certain percentage of alcohol in an assimilable form, and they are usually well borne, they should not, however, be relied on as perfect foods.

A word as to the preparation of egg albumen: To eight ounces of sterile water add the white of one egg, beat up thoroughly and strain through a clean cloth, then flavor with salt or sugar or both, add a little brandy or peptonoids and it is ready for use. Instead of water we may use as a diluent any one of the cereal gruels dextrinized.

As to drugs Bismuth Subnitrate still holds its place as our most useful drug—doses of five to ten grains each are usually well borne by most children. These doses are larger than most of us prescribe, but properly administered in palatable prescriptions will serve to check the bowels already cleared by calomel and oil, but still acting too freely and too frequently, when smaller doses might not do it. So good an authority as Southworth, of New York, advises that ten grains should be given every hour at first to children under one year of age until improvement occurs with the characteristic discoloration of the stools, then every two hours may be sufficient. "The discoloration being caused by hydrogen sulphide in the bowels can be produced by giving lac sulphur in grain doses for a sufficient length of time." When bismuth fails we may add opium, but not in a mixture, in any of its preparations best suited to the individual case. For my own part *Tr. Opii odorata* seems to serve me best, then the preparations of potassium as aids to elimination administered in some of the forms named above or in the very excellent preparation composed of potassium bicarbonate, goldenseal, pancreatin and rhubarb sold ready prepared by the druggists.

Some of the complications to combat are nausea and vomiting, tenesmus and convulsions and extreme prostration. For prostration alcohol in some form is our

best remedy given in suitable doses to meet the requirements of the individual case, some can take very much more than others, but we should be careful that it does not upset the stomach. Burnt whiskey, part of the alcohol being burned away, is to many children an agreeable and by many children better borne than plain whiskey, though of indefinite strength, and for that reason not so reliable a stimulant.

For tenesmus we have in cocaine when properly used a most effective remedy. Some of our best authorities advise it used in  $\frac{1}{4}$  grain doses inserted into the rectum by means of a suppository, this being repeated at three and four hour intervals until the child is relieved.

I believe that far less than that amount is sufficient for most cases,  $\frac{1}{12}$ th to  $\frac{1}{20}$ th grain of cocaine in a readily soluble suppository combined with pulv. Dov. camph., and one grain bismuth subnitrate in my judgment is sufficient for a child eighteen months old. More repeated at three and four hour intervals I fear to be dangerous.

For nausea and vomiting a little shaved ice given frequently, bathing the lips and gums with mint or camphor water often help the little sufferers. I am afraid of cocaine and chloretone and other similar drugs, but believe they serve a useful purpose in the control and prevention of nausea. We should, however, try the milder remedies first.

For convulsions the treatment should be directed to the immediate cause if such be possible, but the appearance of even slight convulsions in the later stages of enterocolitis is an evil omen, and indicates that the brain has suffered from the drain upon all the tissues as well as from the toxic effects of retained poisonous products, of defective secretions and excretions. What to do under such circumstances taxes all the resources of the physician. As for myself I fear that I cannot do enough and I also fear that I may do too much. It seems to me that all treatment in this condition is unsatisfactory. The bromides, hyoscyamus, belladonna have all been tried with doubtful results. Morphine hypodermically to suit

the individual case and to secure immediate relief, then vigorous efforts to secure effective elimination, both from the kidneys and the bowels, is our most reliable plan of treatment, and is sometimes productive of good results.

For high temperature cold packs to the head, cold water enemas, and cold sponging all have their uses within judicious limits. In my judgment it is unwise to administer the coal tar preparations at any time during the later stages of enterocolitis. Enemas of normal salt solution are stimulating, eliminant, and being readily absorbed by the tissues are in my experience our safest means of relieving high temperatures. Ordinarily when daily irrigation of the bowels seems necessary on account of high temperature and foul smelling stools, the child's condition otherwise being good, one or two bowel washings a day is amply sufficient, more, I believe, does harm and the fewer in the aggregate the better. In some cases bowel washing seems to be of great service, in others it, in my judgment, increases tenesmus and produces prostration. Its effects should be closely watched at all times and at the first appearance of symptoms of collapse the washings should be discontinued. The indiscriminate use of high rectal enemas should be looked upon by conservative physicians with condemnation, they should be given by the physician only or by a competent nurse, and only when deemed safe and absolutely necessary.

Again we would do well to avoid undue purgation. Calomel and oil and other purgatives often do good, but I believe in the weak and emaciated little sufferers they do harm more often than they are thought to do, and as most of us are aware, oftentimes aggravate the case and cause its recovery to be retarded.

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#### MISCELLANEOUS.

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In view of its present importance we deem it wise to publish the following which was sent to postmasters in the Southern States by the Treasury Department.



## STEGOMYIA FASCIATA.

Treasury Department,  
Bureau of Public Health and Marine Hospital  
Service,

WASHINGTON, July 31, 1905.

NOTE.—The measures herein mentioned were recommended by the army medical board of 1900 and have been indorsed by the American Public Health Association and by the First International Sanitary Convention of American Republics. They have also been justified by the experiences and observations of the two working parties of the Yellow Fever Institute of this Bureau in Vera Cruz, Mexico, and by the commission of the Pasteur Institute of Paris, France, operating in Rio Janeiro, Brazil. The measures have been tested successfully on a large scale in Havana, Cuba, and during the yellow fever epidemic at Laredo, Texas., 1903.

The infection of yellow fever is carried by mosquitoes, and by no other means is the infection spread.

Persons take the disease by being bitten by mosquitoes that have previously bitten a yellow fever patient.

The mosquito to become infected, must bite a yellow fever patient during the first three days of his attack. These first three days, therefore, are the most important time for preventing the access of mosquitoes to a fever patient.

It is often difficult to decide during the first three days whether a patient has yellow fever; hence the necessity in threatened communities of placing a mosquito bar immediately around every patient who has fever of any kind, and for three days at least.

### FACTS ABOUT SCREENING.

1. The netting used should have meshes fine enough to prevent the passage of mosquitoes (at least 18-20 meshes to the inch).

2. It is important to screen the windows and doors of the house. It is doubly important to screen the beds of fever patients.

3. Mosquitoes can bite through mosquito nets when any part of the patient's body is in contact with the netting.

4. Frequent examination should be made to see that there are no torn places in the netting or that no mosquitoes have found a lodgment inside.

5. The netting should be well tucked in to keep mosquitoes from entering.

6. If mosquitoes are found within the netting they should be killed inside and not merely driven or shaken out.

7. All cases of fever should be promptly reported to the local health officer. Awaiting his arrival they should be covered with a mosquito bar.

1. Mosquitoes live in the vicinity in which they breed. They do not often fly a long distance.

2. Mosquitoes breed only in water—usually in artificial collections of fresh water.

3. The young mosquito, or wriggler, lives in water at least seven to twelve days.

4. Although the wigglers live in water, they must come frequently to the surface to breathe.

5. Coal oil on the surface of the water prevents the wigglers from breathing.

6. Destroy the breeding places and you will destroy the mosquitoes.

7. Empty the water from all tubs, buckets, cans, flower pots, vases, once every forty-eight hours.

8. Fill or drain all pools, ditches, unfilled postholes, and the like.

9. Change regularly every day all water needed in chicken coops, kennels, etc.

10. Treat with coal oil all standing water which cannot be drained (1 ounce of oil will cover 15 square feet of surface). The oil does not affect the water for use if the water is drawn from below.

11. Where oil is applied to standing water it must be distributed evenly over the surface.

12. Put fine wire netting over cisterns, wells, and tanks of water in every day use.

13. Places in which it is undesirable to put oil, such as watering troughs for stock, lily ponds, and so forth can be kept free from wigglers by putting in goldfish or minnows.

14. Clean away all weeds, grass, and bushes about ditches, ponds, and other possible breeding places, since these afford a hiding place for the mosquitoes.

15. Clean up vacant lots and back yards of all cans, tins, bottles, and rubbish.

16. First do away with, or treat, all places where mosquitoes are known to breed, and then begin to work on places where they might breed.

17. Inspect and treat with coal oil, gutters, culverts, ditches, manholes, catching basins, etc., along the roadside. Manhole covers should be screened.

18. Houses should be cleared of mosquitoes by burning 1 pound of insect powder or 2 pounds of sulphur to 1,000 cubic feet of space. The mosquitoes will fall to the floor and should be collected and burned.

19. Success in mosquito destruction depends upon the co-operation of the members of the entire community.

20. While the infection of yellow fever is carried by a single species of mosquito (the *stegomyia*), to insure its destruction it is necessary to destroy all mosquitoes.

In places liable to yellow fever both individuals and communities have an effective method of protecting themselves, as indicated above. Use the mosquito bar at once over all cases of fever until the danger from yellow fever has passed. Destroy all mosquitoes.

WALTER WYMAN,  
Surgeon-General.

## COMMUNICATIONS FROM COUNTY SOCIETIES.

ORANGEBURG, S. C., Sept. 6, 1905.

Last Monday Dr. T. G. Croft, of Aiken, Councillor, 2nd Dist., addressed a meeting of the physicians of Orangeburg County, advising organization of county societies. After his talk, a permanent organization was effected, adopting the constitution and by-laws as proposed by A.

M. A., with only such change as needed to meet local conditions. I am without a copy of this Constitution and By-Laws and will ask you to send me one so that I may order the required number for the society's use.

As soon as the annual dues are paid I will write to you for a charter. Enclosed I send a list of the members enrolled to date. Think this will be greatly augmented in a short while, and finally embrace every legalized practitioner in the county. Please send these members the State Journal. Thanking you, I am,

Very truly yours,  
LIN. C. SHECUT, Sec'y.

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ORANGEBURG COUNTY MEDICAL ASSOCIATION.

Sept. 6, '05.

Prest.—W. L. Pou, St. Matthews.

1st V.-P.—M. J. Dantzler, Ellore.

2nd V.-P.—M. S. Gressett, Branchville.

Sec'y and Treas.—L. C. Shecut, Orangeburg.

A. R. Able, St. Matthews.

L. B. Bates, St. Matthews.

M. G. Salley, Orangeburg.

L. K. Sturkie, Orangeburg.

J. G. Wannamaker, Orangeburg.

J. A. Jeffords, Orangeburg.

D. D. Salley, Orangeburg.

Jesse A. Clifton, Orangeburg.

A. W. Browning, Ellore.

W. H. Lawton, Vance.

S. J. Summers, Cameron.

P. L. Felder, Ellore.

J. M. Oliver, Orangeburg.

T. C. Doyle, Orangeburg.

W. R. Lowman, Orangeburg.

W. L. Mack, Orangeburg.

J. D. S. Fairey, Orangeburg.

A. S. Hydrick, Orangeburg.

D. J. Hydrick, Orangeburg.

Geo. H. Walters, Orangeburg.

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SPARTANBURG, S. C.

Spartanburg County Medical Society held their regular meeting Aug. 25, 1905. Meeting was well attended. Dr. A. D. Cudd read a paper on "Floating Kidney."

Dr. Fred. L. Potts on "Suppurative Appendicitis." Dr. J. H. Allen is ill with typhoid fever.

Dr. H. R. Black is spending a month in Philadelphia.

Drs. J. E. Edwards, of Abbeville, S. C., and A. K. Taylor, of Tarboro, N. C., have located in Spartanburg.

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LETTER TO THE EDITOR FROM THE COUNCILLOR OF THE SECOND DISTRICT.

My dear Doctor:—

I was at Orangeburg yesterday and succeeded in organizing their County Society. They start with a membership of 22, and I believe in a few months will be raised to 30 or 40. They have good material in this county, and I do not see why it will not make one of the best societies in the State. The secretary will shortly send down the list of members to Dr. Whaley and get them on your list for the *Journal*.

I congratulate you and your co-workers in the bright and pithy little journal you give us.

With kind regards, I am,

Very truly yours,

T. G. CROFT.

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UNION, S. C.

Editor *Journal* S. C. Medical Association, Charleston, S. C.

My Dear Sir:—

It is with pleasure that I announce that the Union County Medical Society, immediately upon receipt last April of the new Constitution as recommended by the National Association, was reorganized, and is now working under a charter from the State Association.

This new arrangement has proven very satisfactory to us, and has been the means of adding several members to our society, yet there are a few reputable physicians in the county not members, but we hope to have them enrolled before the next meeting of the State Association.

We find the weekly meetings very satisfactory, with fully as large an attendance as with the monthly, or semi-monthly meetings.



The reading of papers, and the report of clinical cases bring out a very liberal discussion, and each member leaves the meeting with a feeling that he has added to his store of knowledge something new, or something forgotten which will aid him in relieving the ills of his fellow man.

The Union physicians of the old Medical Society started a movement last year to establish an hospital here, and it is very gratifying indeed to note that under the new organization matters are progressing more favorably, and we hope before the autumn is past to have the plans so matured that work shall at least have been begun on the building.

Yours fraternally,  
THEODORE MADDOX, Sec'y.

#### A SPECIMEN FROM THE LAST EXAMINATION BY THE STATE BOARD.

The following is one of the papers presented during the last session of the State Board. It is given literatim and verbatim.

#### SOUTH CAROLINA STATE BOARD OF MEDICAL EXAMINERS.

##### Materia Medica and Therapeutics.

JUNE 13, 14, 15, 1905.

DR. J. L. NAPIER, EXAMINER.

Give dose, intervals between, physiological effect, class, and therapeutics of:—

Question 1. Digitalis Tincture.

Answer (a) Digitalis Tinct. Dose, from 1 to 10m. The Doses can Be givon in intervals of ever 3 hours at 2m Doses for some hours. But in givon Digitalis The heart must Be watched for some times Very small doses means great effect over some people than it do in others. I will say the intervals must Be governed By the action of the heart.

(b) Digitalis has great effects over the heart muscles and percautiones must Be looked after when the administer this drug. It slows the heart beat and does So By the effects it has over the muscle of the heart.

(c) In therapeutics uses of digitalis Is used in cases where the heart is beating to fast and is used in cases of heart deases. Mitral regurgitation and Oartic regurgitation, and is used in cases of Nephritis where the heart is increased in its action.

It can be used in cases in where the heart is increase in its force and the muscle of the heart is not effected.

Question 2. Strophanthus Tincture.

Answer (a)—Strophanthus Tinct. Dose 1 to 3m. It can be givon at intervals of 3 hours. at 3m at a dose. and can be givon in larger doses.

(b) Physiological effect. it/has a great effect over gastro intestine tract it actes as a eritant to the stomach when it is givon in large doses.

(c) and it is used in cases of deases of the gastro intestine tract as in eritation. it is also use in a general weakon system.

Question 3.—Strychnine Sulphate.

Answer (a) Strychnine Sulphat. Dose 1-60 to 1-30 gr. In ad ministerig it must be guvern By the heart action and it has greater effectes over some people than it dow over other.

It can be givon at intervals. 1-60 gr 3 times a day. with no bad Results.

(b) The Physiological effects is its great effectes of stimulating the nerves of the System and increasing the action of the heart. and it does this By the effectes it has over the nerves of the heart centers.

(c) Therapeutics actions is its uses in increasing the Rates of the heart Beat and is use in cases of Stimulating the Nerveous System and Sometimes used in cases of Blood effection where the Blood has a slow action. used in cases of nerveous deases, to stimulate them.

Question 4. Veratrum Viride Tincture.

Answer (a) Veratrum Viride Tinct. Dose, from 1 to 2 dr. It can be givon at intervals 1 dr at 4 hours intervals.

(b) Physiological effectes it effectes or rather a eritante to the intestine camal use in case of causing the intestine canal wall to become in a acting condition.

(c) And is used in cases of penuomes and in any Organization in the intestine canal.

Question 5.—Nitro Glycerine.

Answer (a) Nito glycerine? Dose, gr 1-100 to 1-150. The intervals of giving this drug must be givon By the effectes it gives or rather effectes the heart. But it can be givon at intervales of 1-50 gr. ever 3 hours with Out any bad Results.

(b) Physiological effect. it has a effect to stimulate the heart centers and increase the action of the heart, and it increases the action of the heart By effecting the centers of the heart and effecting the muscle of the heart.

(c) Therapeutics effection of nitro glycerine Is used in case of heart deases in where the heart is become slowed in its effection.

In cases of frightes in where the heart has become slowed. Sometimes it is used in cases of patient getting too much anasthenia and the heart becoming slowed.

In answering the following questions, give doses of drugs used; the frequency with which the dose is repeated; the physiological effect, or why did you give it.

Question 1.—Dysentery.

Answer Dysentery. first in a case of Dysentery first give a purge. and this purge is given to clean Out all the intestine canal now the drugs used for the Dysentery can have a better effect. For Dysentery.

Bithmus Sub.	dr. 3
Bithmus Subgal.	dr. 3
Opji Tr.	dr. 2
Elixir pepsin	Dr 2
aquea to make	oz. 4
M. Sig. teaspoonful in little water ever (2) two hours.	

In this I give the Bithmus for a protecting coat for the intestine wall.

And the Opium for or rather to controle the pirstactic movement of the intestine. and the pepsin more as a effect for the Stomach.

Question 2.—Cholera Infantum.

Answer IN a case of this kind I would give doses of morphine 1-30 to a child and increase as they required to be done The resion of giving morphine is to releave the child of its Suffering and to keep it at Rest.

Question 3.—Pneumonia.

Answer. Pneumonia, in case of this kind you wold use hot application to effected part and wold give strychnine to increase the heart action when it is Kneeded.

wold use hot applications to keep the effected part warm to try and keep it from becoming in a consolidated forme, wold use strychnine to increase the action of the heart when it has become slowned. By the great worke it has to do. When the pneumonia it depresses Over the heart and causes it to become slowned. then give Strychnine.

Question 4.—Pleuritis.

Answer. None.

Question 5.—Hay fever.

Answer. None.

Question 6.—Partussis.

Answer. None.

Question 7.—Nephritis Acute.

Answer. In Nephritic acute wold give in this condition get the skin in good acting condition and wold give acetate Potash for the effectes of aleminating.

The kitnys in a good acting condition. give 5gr. 3 times a day. Buch is use 3m 3 times a day Sometimes.

But you wontes to get the Skin in a good acting condition for or rather to keep work off of the knitnys and acetate potash to keep them in good condition.

Question 8.—Icterus Catarrhal.

Answer. None.

Question 9.—Laryngismus Stridulus.

Answer. None.

Question 10.—Rheumatism Acute.

Answer. Rheumatism acute. In this condition wold give Salcyate of Soda. in Doses from 1ogr. ever 4 hours.

wold give it for its great effect it has over the muscles and wine cholconm is givon in dose of 5m 3 times a day for the effect that it has over the muscles.

## NOTES AND REVIEWS.

### Surgery.

T. P. WHALEY, M. D.

#### APPENDIX AND PELVIC DISEASE.

In the *American Journal of Obstetrics and Diseases of Women and Children*, August, 1905, Reuben Peterson, of Ann Arbor, Mich., con-

tributes an excellent article on the "Relation of the Appendix to Pelvic Diseases," claiming that the appendix should be removed as a routine measure when doing other intra-abdominal work on the pelvic organs, and quotes 200 cases, previously reported by him, in which just a little over 50% of the appendices were found to be microscopically normal, and reciting 82 recent cases in which 49%, or practically 50%, were found normal. He concludes by stating that, "Since it is impossible for the surgeon by gross appearances alone, to determine which appendix is diseased, and since nearly 50% of appendices, when the abdomen is opened for other purposes, are found microscopically to be diseased, it is the surgeon's duty in the absense of contra-indications, to remove the appendix in every case, otherwise he will leave behind diseased appendices which may prove a subsequent source of suffering to the patient."

#### REMOVAL OF APPENDIX WHEN OPERATING FOR OTHER TROUBLE IN THE PELVIS.

In the *American Journal of Obstetrics and Diseases of Women and Children*, August, 1905, Dr. W. A. Baker, of Boston, Mass., contributes an article entitled "Reasons for Removing the Vermiform Appendix in Nearly all Cases Where the Abdomen is Opened for Other Lesions." He cites a number of cases and concludes that:

First: The presence of adhesions of, or fecal concretions within, the appendix are not the only evidences of appendicitis which should influence the surgeon for its removal.

Second: The appearance of the normal appendix at the time of the operation has proved to be unreliable, as three-fifths of the cases reported were suffering from chronic appendicitis.

Third: The advantages to be derived as a propylactic measure for the removal of the appendix even in cases which prove normal far outweigh the slight additional risk incurred by operation.

Fourth: The great frequency with which appendicular troubles present themselves warrant not only the removal of the appendix, where it is easily accessible, when performing abdominal section for other lesions, but also the careful searching for and removal of it even though it may appear normal from its gross appearance.

#### CONCLUSIONS AS TO THE EFFECTS OF X-RAYS ON MALIGNANT GROWTHS.

In the *Annals of Surgery* for August, 1905, Dr. Wm. B. Coley, of New York, concludes a most excellent article on "Final Results of the X-Ray Treatment of Cancer," including Sarcoma, as follows:



The results of the x-ray treatment of malignant tumors up to the present time have proven,

1. That the x-ray exerts a powerful influence upon cancer cells of all varieties, but most marked in cases of cutaneous cancer.

2. In many cases, chiefly in superficial epithelioma, the entire tumor may disappear, probably by reason of fatty degeneration of the tumor cells with subsequent absorption.

3. In a much smaller number of cases of deep-seated tumors, chiefly cancer of the breast and glandular sarcoma, tumors have disappeared under prolonged x-ray treatment. In nearly every one of these cases, however, that has been carefully traced to final result, there has been a local or general return of the disease within a few months to two years.

4. In view of this practically constant tendency to early recurrence, furthermore, in the absence of any reported cases well beyond three years, the method should never be used except in inoperable cases, or as a prophylactic after operation, as a possible, though not yet proven, means of avoiding recurrence.

5. The use of the x-ray as a pre-operative measure in other than cutaneous cancer is contra-indicated, 1, because the agent has not yet been proven to be curative; 2, because of serious risks of an extension of the disease to inaccessible glands or to the other regions by metastases during the period required for a trial of the x-ray.

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### Materia Medica and Therapeutics.

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J. L. NAPIER, M. D.

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At the request of the editor of *Journal*, I have agreed to edit the department of Materia Medica and Therapeutics. It will be my aim to make this part of the *Journal* as much of a success as I can. To do so I ask the members of the Association to assist me by reporting the treatment of any of their cases of interest, especially any thing new they may have discovered in treatment. Also any new drugs they may have used with success.

No one man can settle any thing in our profession, but by compiling the results of treatment in any given disease, or the use of any particular drug, a definite conclusion can be reached. There is no reason why the *Journal* should not be the equal of any and all that is necessary to make it so is for every man to do his part.

J. L. NAPIER.

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### THE TREATMENT OF HEMOPTYSIS.

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Francis Hare, of Brisbane, in *American Medicine*, of April 1, 1905, reports his results and those of others in his method of treatment. He sums up the matter by stating that of 16 attacks of hemoptysis occurring in 9 consecutive cases (8 tuberculous, 1 mitral) and treated by amyl nitrite inhalation, all save one ceased within

three minutes; in the exception cessation was delayed for ten minutes.

The treatment has obvious advantages. In hemoptysis there is a highly vicious circle in operation. The intrapulmonary irritation of effused blood causes cough; coughing, like any other sudden exertion, causes rise of blood-pressure; rise of blood-pressure induces fresh bleeding; and so on, the circle continuing to revolve in many cases until the loss of blood has been sufficient to reduce blood-pressure materially and thus end the hemorrhage. This natural cure was at one time imitated by physicians who resorted to the lancet. The treatment by amyl nitrite is another imitation, less complete, but more economic than venesection. The circle is broken at the same point and by the same means, namely, reduction of general blood-pressure, but the blood being saved, the procedure may be repeated as often as necessary.

The drug causes no interference with cough; it is the influx of blood to the ulcerated lung tissue which is stopped, not the efflux from the bronchial tubes. Consequently blood-pressure already effused is rapidly cleared, retention and subsequent septic pneumonia obviated.

So far as the writer knows the treatment is absolutely safe, and is easily and rapidly applied. Hence it can be used by the patient in the absence of professional supervision, a point of considerable practical importance. It is a matter for surprise that the freedom from hemorrhage conferred by a drug whose influence is so fleeting should last so long as seems to be the case.

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### SCOPOLAMINE AS A GENERAL ANESTHETIC.

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Terrier (*Bull. et Mem. de la Soc. de Paris*, No. 6, 1905) in a report on the use of scopolamine, as a general anesthetic in surgical practice, publishes the results of twenty-six trials of this agent. Scopolamine, the anesthetic properties of which were brought under the notice of French surgeons by Desjardine at the end of last year, is extracted from the *Scopolia japonica*, and is chemically identical with hyoscyne, although possessing different physiological action. The anesthetic effects were studied by injecting subcutaneously a solution of a milligramme of scopolamine with a centigramme of morphine in a cubic centimeter of distilled water. An injection of this solution made four hours before the time of the surgical operation is followed by a second injection after an interval of two hours, and by a third after a further interval of one hour. After the first injection the patient, in the course of half an hour, gradually falls into a deep but quite natural sleep, the respirations being quiet and the reflex movements readily excitable by external influences. After the second injection the reflexes are diminished, the respirations become less frequent, and the pulse is accelerated. The patient is now in a heavy sleep, from which he can be aroused for a moment by shaking. The third puncture, which is not felt by the patient, is followed by a still deeper but quite physiological sleep, by dilatation of the minute blood-vessels of the face, indicated by congestion, the pulse being full, regular, and rapid. The pupils are dilated

and the eyeballs rotated upward and a little outward. Notwithstanding this state of intense stupor there is no complete relaxation of the limbs, and it is necessary during the removal of the patient to the table, and also during the operation, to avoid any disturbance from noise or talking, and to protect the eyes from light. There is, however, marked and persistent anesthesia over the whole of the surface of the body, and the cutaneous sensibility to pinching and pricking is completely abolished. The patient continues to sleep deeply and quietly for four or five hours after the operation, and after a slow awakening is restored to a natural condition. Anesthesia persists for some time after the renewal of the cerebral functions, so that the patient remains comfortable and free from pain in the wound for the first twenty-four hours after the operation. There is freedom also from headache and from nausea and vomiting.

The author points out that this method of producing general anesthesia has the following advantages: (1) It suppresses any apprehension of the operation. (2) The state of anesthesia is not preceded by excitement, and thus a cause of syncope is avoided. (3) The nausea, vomiting, and malaise which so often follow other methods of producing anesthesia are not observed after the use of scopolamine. The patient awakes in a normal manner from his deep sleep, and then does not feel the slightest malaise, and is able at once to take fluid and even solid nourishment. (4) The persistence of anesthesia after the awakening of the patient enables him to pass the night in comfort and in freedom from pain at the seat of operation. (5) The injection of scopolamine is not followed by albuminuria. (6) This agent does not act on the heart or lungs, and causes no bronchial irritation.

On the other hand, there are certain disadvantages attending this new method. Scopolamine is very uncertain in its action, and it is sometimes necessary to have recourse to the inhalation of chloroform or ether. It is, moreover, a very unstable substance, so that it is necessary to use only such as is quite fresh and pure. A serious inconvenience is the vasodilatation it causes, which in operations on very vascular tissues necessitates careful precautions for arresting hemorrhage, and prolongs the operation. Another disadvantage attending the anesthetic action of scopolamine is the persistence during such action of contraction of the abdominal wall. This complication, which tends to contra-indicate the use of scopolamine as an anesthetic in abdominal surgery, might, the author thinks, be prevented by making only one subcutaneous injection of the solution.

In conclusion, the author holds that scopolamine possesses the great advantage over all other general anesthetic agents of being free from danger.—*British Medical Journal*, March 25, 1905.

## Obstetrics and Pediatrics.

LANE MULLALLY, M. D.

*Cesarean Section*.—Much attention is at present being paid to the subject of Cesarean Section, and the results obtained by various obstetricians in cases of Cesarean section encourage one to extend the field of this operation.

Voorhees (*Am. Jour. of Obstet. &c.*, Aug.) in a most excellent article entitled, "Seven Cesarean Sections," says:

Every day the operation of Cesarean Section is becoming more and more common, and the indications more and more relative. Only a little over a decade ago to deliver a woman by the abdominal route meant taking great chances for the mother's life. \* \* \* \* \* To-day, a Cesarean section creates no wonder. \* \* \* \*

The results at large are so excellent that no careful surgeon, who is sure of his aseptic technique, who has an average amount of skill, and who has ordinary assistance, should be afraid to perform the operation on proper cases. Voorhees says the greatest danger is *infection*. That in the border-line cases where labor has been induced with the hope of a normal process or an easy forceps or version delivery, the possibility of infection always confronts us, but in some of these cases he believes you should take the chance of infection, though almost all operators who have the lowest mortality for Cesarean section will not take such chances. That Williams and others advocate in cases where one is not absolutely sure of his asepsis, that if Cesarean section is decided upon a modified Poro operation ought to be performed.

Spreading the omentum over the uterine incision when infection is possible will tend to localize the process at this site and prevent an involvement of the general peritoneum.

The second danger is hemorrhage, mostly to be feared when the operation is done where labor has started.

The third danger is shock, which he claims as a rule, is much less after Cesarean section than after prolonged forceps operations or a difficult craniotomy. When a hysterectomy is performed after removing the child the shock is considerable, consequently this extra risk is an additional contra-indication against removal of uterus.



The fourth danger is in the detachment of an embolus.

Voorhees says that the absolute indication for Cesarean section should be a pelvic diameter 7 cm. or less. He believes that if a version is done when the child is of a fair size and the pelvis moderately contracted (an internal conjugate of 8.50 cm. or under) especially in justo-minor pelvis, most of the babies will be lost. He condemns prolonged high forceps operation, pulling for one half, three-quarters or an hour without any advance of the head. When, however, the woman is in unfavorable surroundings and is already in such poor condition after a protracted labor and bad management that infection is certain, craniotomy should be selected, even though the child is living and in good condition. Though difficult craniotomy is often more dangerous for the mother than Cesarean section.

The operation for symphyseotomy is surely on the decline. That when any operation performed in the interest of the child carries with it such a high fetal and maternal mortality, when the convalescence from any operation is so prolonged and so interrupted by annoying and dangerous complications, and when the patient can be threatened with misery of chronic invalidism, we have no right in recommending a symphyseotomy in place of another operation. Such as Cesarean section which is less dangerous and presents far better results. Voorhees closes his article with the following conclusions:

1. That Cesarean section is a dangerous operation only when infection is present.

2. That there are too many fetal deaths from the other major operations.

3. That in view of the low maternal mortality the field for Cesarean section should be broadened.

4. That in contracted pelvis of a moderate degree (in the borderline cases) a late induction of labor is justifiable.

5. That when possible difficult versions prolonged high forceps operations performed early in labor should be avoided.

6. That craniotomy on a living baby is an operation only of necessity and emergency.

7. That symphyseotomy is an operation of the past. Cesarean section in late labor. Holmes (*Am. Jour. Obstetrics, &c.*) believes that the appropriate time for abdominal hysterectomy is at term before labor has begun or not long after active contractions have been in progress. He believes that in contracted pelvis the upper limit for an absolute indication for a Cesarean section should be 7 cm., at the same time he still believes that craniotomy even on the living child is the only rational and scientific procedure in certain cases.

The contra-indications to Cesarean section in late labor center in the following facts:

1. Prolonged labor lowers the woman's resistance to shock.

2. Prolonged labor conduces to atony of the uterus, therefore, to hemorrhage, occasionally necessitating hysterectomy.

3. Prolonged labor develops certain effete substances, catabolic products, which are eliminated more slowly than they are produced; possibly lowering immunity by a species of auto-intoxication, therefore infection is more prone to occur.

4. During a protracted labor certain secretions, blood, mucus, etc., are poured into the uterus and vagina, which offer excellent culture media for the development of bacteria, normally present in the parturient canal, or introduced by examinations. In protracted labor we often see intra-partum infections, which promptly disappear with the evacuation of the uterus, or run a course as a puerperal infection.

This danger is increased by attempts to deliver per vaginam before the abdomen is opened.

5. After the membranes have projected through the os externum, or the head has moulded into the os, they are exposed to the contamination of the vagina; in removing the secundines and the child through the uterine incision they may soil the peritoneum or wound.

6. The prolonged labor frequently is the determining factor in the death of the child, or at least so jeopardizes its life that its prospects are curtailed.

If attempts to deliver have been instituted, it should be remembered that forceps occasionally will seriously maim the child, so it dies later, yet in utero the heart tones remain regular and strong.

He reports a case operated on in the country, and cites that the favorable circumstances for Cesarean section when the good condition of the child, natural strength of the woman, and that she was in the country, thereby minimizing the danger of infection.

#### PREVENTION AND MANAGEMENT OF SUMMER DIARRHOEA.

Kerley (*Med. Record*, New York) says that this is entirely a matter of education, that his orders in any household he attends where there are children is: As soon as the first sign of intestinal trouble shows itself stop milk, and give two teaspoonfuls of castor oil.

Put the child in the coolest room in the house, and secure rest and quiet. Use boiled water for drinking. Barley water or rice is used for nourishment.

When you return to the milk have it skimmed and give it in cereal water, in small quantities, ½ ounce at a feeding.

He relies on just four drugs, Calomel, Castor oil, Bismuth and Opium. He gives Bismuth in large doses, but is very careful in the administration of Opium, using Dover's powder.

He describes the indications for irrigation of the colon.

Southport (*Med. Record*, N. Y.) says, from the moment the child is born pro-phylactic measures should be instituted to prevent summer diarrhoea, and the most important is breast nursing. The usual diagnosis of "teething" assigned for every illness in young children is one of the difficulties that has to be overcome.

## GYNECOLOGY.

CHAS. M. REES, M. D.

### THE VAGINAL VS. THE ABDOMINAL ROUTE IN PELVIC OPERATIONS.

From the transactions of the Southern Surgical and Gynecological Association, 1903. In an excellent paper on "The Technique of Pelvic Operations, N. Y., by Vaginal Section," Dr. J. Riddle Goffe, N. Y., the author strongly advocates the adoption of vaginal section, and states that he is glad to report continued satisfactory results in his hands, and of its steady growth in popularity throughout the country. The most marked examples of this are at St. Joseph's Hospital, Yonkers, New York, in which the entire visiting staff of surgeons—six in all—have as a routine method adopted the vaginal route for pelvic diseases to the almost complete exclusion of abdominal section, and with such improvement in their statistics that they are all ardent advocates of this method. With them every disease confined to the true pelvis is attacked through the vagina. In summing up his experience the author says:

The following conclusions are fairly indicated, not only from my own personal experience, but from what I believe a candid study of the table of cases would teach.

1. The vaginal route is most useful for reaching and operating upon the round ligaments, in cases of retroversion of the uterus or procidentia; also for removal of small fibroids, either subperitoneal or pediculated, for conservative work on the ovaries or tubes, or for removal of these organs.

2. The posterior incision is most useful for drainage in cases of pyosalpinx salpingitis, pelvic abscess, some cases of tubal pregnancy with hæmatocele and puerperal sepsis either with or without involvement of the tubes? for oophorosalingectomy, when the ovary is held backward and downward by old adhesions, and even in some cases of general septic peritonitis. The author further states: The more I see of this work the more I am impressed with the important truth that no pus tube should be attached by any other route than by the vagina. He further says, in my hands the scope of the operation, i. e., the conditions to which it is applicable, is steadily widening. It is no longer confined, on the one hand,

to simple puncture and drainage, nor limited on the other hand to the radical operation of hysterectomy. All the intermediate procedures that are called for by the multifarious pathological conditions found in a woman's pelvis find their most direct route through the vagina.

Two incisions are employed by Dr. Goffe to reach the pelvic cavity through the vagina; one posterior to the cervix into Douglas's pouch, and the other anterior to the cervix separating the bladder from the uterus. The anterior incision is the one which he most frequently employs.

The anterior incision is made as follows: A transverse incision is made in front of the cervix, as is done for vaginal hysterectomy, through the vaginal mucous membrane and sheath from the uterus up to the peritoneal fold. The second incision consists of a longitudinal incision through the vaginal mucus membrane and sheath throughout its entire length. This second incision is accomplished by grasping the edge of this transverse incision, either side of its middle point, by two artery clamps. Tension upon these puts the anterior vaginal wall upon the stretch, and an incision is made with the knife from the neck of the bladder down to the centre of the transverse incision. The purpose of the second incision and separation of the bladder is to secure sufficient room in which to work. In the discussion which follows Dr. Goffe's paper, the consensus of opinion and experience was not in accord with Dr. Goffe's method, and rather than gaining in popularity, was losing. Those surgeons who had for a time given up abdominal section for the vaginal route, were fast returning to the abdominal incision, and found the vaginal incision greatly restricted in its usefulness.

### THE MORTALITY OF GOITRE CASES WITH REFERENCE TO GYNECOLOGICAL OPERATIONS.

In the September, 1905, number of *The American Journal of Obstetrics and the Diseases of Women and Children*, Dr. Barton Cook Hirst, Philadelphia, in a paper, "The Mortality of operations, other than strumectomy, in cases of exophthalmic Goitre, with special reference to Gynecological Operations." No one had sufficient experience with this complication to give an opinion. To learn the collective experience of American surgeons Dr. Hirst addressed 366 communications to members of National Societies of Surgery and Gynecology. He was able to collect 71 cases upon which various operations had been made, from extraction of teeth to the gravest abdominal section, and amputation of limbs. It appears from the statistics that the existence of Exophthalmic Goitre, adds more than 15% to the mortality of any operation performed on the patient.

Consequently an operation of election, such as suspension of the uterus or plastic operations in the vagina should be considered unjustifiable on such patients unless a preparatory or curative treatment is discovered that will lessen the danger. Local anaesthesia may be demonstrated to be preferable to general anaesthesia, but while the subjects of exophthalmic goitre cannot be said to take an anaesthetic well the alarming symptoms of acute thyroïdism do not, as a rule, appear during or directly after the anaesthetic, but usually at the expiration of a day or two when the effects of the anaesthetic have worn off.



Possibly the best results may be obtained with Barker's method of employing adrenalin chloride and blucain.

Dr. Hirst reports two cases with exophthalmic goitre where he was forced to make operations, both cases recovered. In one case there was profound collapse two days after operation, when the patient's pulse rose to 180. Some improvement was shown after hypodermoclysis and heart stimulant. A complete and rapid recovery was apparently secured in the next three or four days by the administration of suprarenal extract in three grain doses every four hours. He thinks intravenous injections of adrenalin chloride would be more efficacious, and will be his choice in the presence of urgent symptoms in future.

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### JOURNAL AND BOOK REVIEWS.

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We have received a copy of the transactions of the Hawaiian Territory Medical Society. It is a neat volume, and contains many thoroughly readable articles; and reflects great credit upon the Society that publishes it.

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One of the spiciest little Journals that comes to the Secretary is the *American Medical Journalist*. It contains many very readable articles, and its last issue seems to be chiefly directed against the various transactions of the American Medical Association, especially against the Journal. We rather think that there is a great deal of truth in what it has to say; and advise all who wish to know both sides of the question to read it. It is published by D. O'Gorman, of New York.

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There has come to our office the *Washington Medical Annals*, Volume IV, No. 3. It is issued bi-monthly, and is a journal of the Medical Society of the District of Columbia. There are some excellent articles in it, and should be of considerable value to the District.

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We beg to acknowledge the receipt of number II of the *Ohio State Medical Journal*, and we are glad to welcome Ohio into the list of the State Associations publishing journals.

The frontispiece is well gotten up and contains a map of the State, divided into counties and districts. A very excellent idea; but not one that we would wish to continue for any length of time. We have no doubt that the map of Ohio is an attractive proposition; but not one we would wish to stare us in the face month after month, and year after year. We suppose that Ohio will change this later on for a more attractive cover page. The journal is a much larger one than ours, and is more on the magazine order. We wish Ohio well, and think that such a large State can well support a good journal.

---

The last number of the *American Journal of Urology* has just come to the office of the Secretary, and it is an exceedingly high grade Journal. It contains many excellent articles, and is a Journal that should be on the desk of every surgeon, and is *par excellence* the leading Journal in that line.

---

To those who are not thoroughly familiar with the mosquito theory in relation to yellow fever, and the history of the *Stegomyia fasciata*, we would respectfully refer them to Volume XIII of the *Yellow Fever Institute*, published as far back as March, 1903, which gives the report of working party No. 1 at Vera Cruz. It is published by the Government, and can be obtained by any one desiring it, from the Surgeon General, unless the issue has been exhausted.

---

There is a report to the effect that Doctors P. E. and John J. Archinard, of New Orleans, think that they have detected the yellow fever germ. This germ, which has been puzzling Bacteriologists for years and so far has eluded the best of them, would confer a great blessing upon mankind if it would allow itself to be discovered. Especially would this be the case, if it would allow itself to be discovered in New Orleans at present.

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[The Secretary begs to publish the following list of Counties with members.]

The following Counties, with members, have thus far affiliated themselves with the Association under the new constitution. Delinquent Counties or those contemplating affiliation with the State body are requested to do so not later than November 1st, as the list will then be closed for the fiscal year.

County Secretaries are requested to report any errors or omissions promptly, so that corrections can be made for the next issue.

T. P. WHALEY, M. D., Secretary,  
Charleston. S. C.

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C. W. Barron.....	New Brookland.
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F. A. Smith.....	Mullins.

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J. A. Faison.....	Bennettsville.
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D. Hamer.....	McColl.

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## South Carolina Medical Association

Next Annual Meeting at Columbia, S. C., April 18th, 1906.

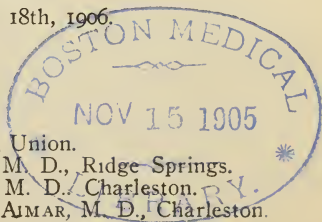
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# THE JOURNAL

OF THE

## SOUTH CAROLINA MEDICAL ASSOCIATION.

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4 Vanderhorst Street, Charleston. S. C.

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 Editor.                                      Associate Editor.  
 C. P. AIMAR, Managing Editor.

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THE JOURNAL is published monthly under the auspices of the South Carolina Medical Association. Members who do not receive their copies will please notify the Managing Editor at once. Secretaries of county societies are requested to send reports of their meetings, and items of news that may be of interest to the profession. Original articles are solicited. Articles should be type-written; and illustrations sent with articles will be printed at the expense of the writer. Reprints will be furnished at the rate of 75c. a page for a hundred pages.

All matter must be in the hands of the editor by the 10th of each month.

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### EDITORIAL COMMENT.

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#### YELLOW FEVER INVESTIGATIONS.

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In a preliminary report, Drs. Pothier, Hume, Watson, and Couret, of New Orleans, announce the discovery of hitherto undescribed cells in the blood of yellow fever patients. These cells "vary in size from twice the diameter of a pneumococcus to one-fourth the diameter of a red cell, and vary in shape from an ovoid to a sphere." They stain poorly by the usual method, but with Delafield's hematoxylin and an aqueous solution of eosin the nucleus stains deeply, showing two to four chromatin granules, while the protoplasm is colored a light bluish pink and is surrounded by a well-defined membrane, more deeply stained, with a deeply-stained spot in one pole. A significant fact is that the bodies are found only in the early days of the fever, at which time alone patients are capable of infecting mosquitoes. The cells were observed in the stomachs

of newly infected mosquitoes which were raised from eggs and allowed to bite yellow fever patients in the first few days of sickness, but after the lapse of nine hours they could no longer be found, presumably because of partial digestion of the blood. One hundred control specimens taken at random from patients in the Charity Hospital failed to show the bodies, and in four slides taken from yellow fever patients in Vera Cruz in 1902 they were found. To test the diagnostic value of their observations, seven numbered slides were submitted for examination and were correctly diagnosed. "Four were from yellow fever cases on the second and third day, two from each case, and three from other diseases. One yellow fever slide was alone miscalled as negative, but its duplicate was correctly stated to be positive. As well as can be judged from their brief report, the New Orleans investigators did their work very carefully and endeavored to exclude all possible sources of error. We shall await with keen interest a more extended report, and earnestly trust that their striking results will receive confirmation by the work of other investigators.

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#### AN OUTRAGEOUS PROCEEDING.

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Readers of the *Journal of the American Medical Association* will recall the *exposé* made a few weeks ago of the outrageous perversion by the M. J. Breitenbach Co. of the report of the Porto Rico Anaemia Commission. The report of this commission was doctored in such a way as to make it appear that Gude's peptomangan was endorsed as being superior to other preparations of iron, whereas Bland's pills and Vallet's mass in reality gave the best results. In a letter to the *Journal A. M. A.*, dated Sept. 18th, the members of the commission themselves call attention to the "erroneous deductions and half-quotations" by which their conclusions were twisted out of shape and made to serve the purpose of advertising the wares of the Breitenbach Co. In or-



der to emphasize the difference between the drugs employed, they cite "eighteen pairs of cases of like type . . . whose initial haemoglobins absolutely or nearly correspond." Of these eighteen cases, "the initial average of haemoglobin percentage in the cases treated by Bland's pills was 21.9; in those treated by pepto-mangan (Gude), 20.7; the average number of days under treatment was 48.7 in the cases treated by Bland's pills; in those treated by pepto-mangan (Gude), 80.7; the average gain in haemoglobin under Bland's pills was 68.1 per cent.; under pepto-mangan (Gude), 62.3 per cent." It is a little hard to understand how such a perversion could have been other than intentional. The Breitenbach Co. no doubt realized that their advertisement would reach a larger number of physicians than the original report or any journal through whose columns the truth might be told, so that even if their action should be exposed they would still reap benefits therefrom.

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#### STATE JOURNALS ASKED TO CO-OPERATE.

At the last meeting of the House of Delegates of the American Medical Association, the following resolution, proposed by Dr. E. Eliot Harris, of New York City, was unanimously adopted:

"RESOLVED, That the committees on publication of the journals of medicine published by the State medical associations affiliated with this body be asked to assist the Board of Trustees in their efforts to suppress the advertisement of medical nostrums and to co-operate in the work of securing pure food and pure drug laws in the United States."

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A very unusual error occurred in making up the September issue of the *Journal*, viz: the misplacement of leaves in a large number of copies. The publishers regret very much that such an accident should have happened, and have willingly agreed to republish the issue at as early a date as possible.

#### ORIGINAL ARTICLES.

##### SHOULD THE RADICAL CURE OF HERNIA BE ATTEMPTED BY MEDIAN ABDOMINAL SECTION?

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R. S. CATHCART, M. D., CHARLESTON. S. C.

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Reference to the literature as given in the text books and medical journals of the past few years demonstrates that hernia and its radical cure has taxed the minds and skill of many operators. More than 25 methods have been devised for the radical cure of the inguinal variety alone, by as many different men. Some of these operations have become obsolete, but many of them still have their advocates, which fact alone demonstrates that the profession is at variance as to the most suitable operation to be selected.

Evidence shows that the majority of surgeons of this country have narrowed the choice of operation for the radical cure of this variety of hernia to four methods:—Bassini's, Halstead, Bloodgood's, and Kocher's. None is suitable to every variety of inguinal protrusion, and in this as in every other class of surgery, men will be called upon to exercise their ingenuity and experience. It is unwise to adhere absolutely to any one method, and it is far better surgery to change the technic to suit the individual case.

A young child of a prominent surgeon was asked: What is meant by operating? After thinking she tersely replied: "Operating means the making of the insides of people right." It would be well for every surgeon to have this answer indelibly impressed on his mind and in selecting or doing any radical operation, choose that which brings the parts as nearly as possible into their normal shape and relation.

The question of operating for hernia by abdominal section was first discussed by Lawson Tait, who advocated this method for the reduction of strangulated

hernia. This was not met with favor and Jacobson in his text book condemns it most strongly for five reasons:—

1st. "Operations for strangulated hernia must sometimes be done by the general practitioner. The old and well established operation which is usually extra peritoneal is safer in their hands than a section. Also that shock is greater.

2nd. Reduction of intestines is not easy when adhesions exist.

3rd. Intestines may be tightly nipped and give way when pulled on through a median incision, thereby soiling the peritoneum, etc.

4th. All surgeons want a radical cure, and he does not think that any intra-peritoneal operation will secure radical results in inguinal hernia.

5th. It creates two potential hernial openings instead of one."

These are strong arguments against abdominal section, but, with the exception of the last two apply only to the strangulated variety.

I believe that the internal abdominal ring can be permanently closed or narrowed to the extent of preventing the escape of intestine through it by intra peritoneal operation (abdominal section) thereby producing a radical cure.

None of us would advocate the opening of the abdomen through the median incision for the radical cure of all inguinal hernia, but if we knew that the internal ring could be permanently restored to its normal size or calibre from within the abdominal cavity, we would have a method with a wide field of usefulness, and in some instances an operation of choice.

1st: In those cases known as Richter's hernia, a normal inguinal canal, with a small tip or half the circumference of the intestine fastened in the ring, all acute symptoms of strangulation or obstruction being present without the presence of a tumor in the ring or canal. These could be easily reduced from the internal abdomen, and one would have the opportunity of seeing the condition of the constricted tip returned to the cavity,

which he could not have in the operation by opening the canal.

2nd: It would be a valuable procedure in those cases of strangulated hernia that are reduced *en masse* or *en bloc*, or those in which from the constriction, bands form later, producing obstruction. In these cases you have to open the abdomen to relieve the condition, and how much better one would feel about his patient if he knew that he could at the same time restore to its normal size the opening that had caused the mischief, and would do so again unless subjected to a second operation later.

3rd: Those individuals with hernia that have to submit to abdominal section for other causes. If at the same time, and through the same incision you cure their hernia, you remove a source of constant danger, and enhance your value as an operator.

In these three classes you would surely be "making the insides of people right," or placing them in as near a normal, or natural condition, as possible.

Lately I have operated on a case in which the patient had an inguinal hernia for years, which she kept in place with a truss. It became strangulated, and was reduced by her physician with some little difficulty. Four days after the reduction she had symptoms of obstruction of the bowel. The inguinal canal was examined, and no evidence of hernia was found. The abdomen was opened in the middle line, and about two inches of the small intestine was found constricted by bands, very much inflamed and thickened. The obstruction having been released, the gut was returned to the cavity, it being judged that the constricted part of the gut would repair itself. The right side of the abdominal incision was retracted forcibly, and search made for the internal ring. It was found without any trouble, and I was struck with the ease and facility that work could be done in this region. With dissecting forceps a small portion of the sac was pulled out of the canal, and cut off; the stump of that portion in the canal was caught up with a purse string suture of chromic gut, the suture also in-



cluding the transversalis fascia, forming the ring. After this was tied, thereby bringing the stump and holding it in the ring, it was transfixed and tied again. The peritoneum was stitched over this, the abdomen closed, and the patient made an uneventful recovery. It has been over four months now since this operation; the patient is all about attending to her duties, that of a nurse, without wearing her truss, which she had not been without for over ten years, and there has been no return of her hernia.

The internal ring can be closed or narrowed from within the abdomen by the method just described, and I believe will hold in a great many cases. More of the sac can be removed, and if there are not many adhesions, all of it; and I would do this in other cases and also make raw the edges of the opening.

In cases in which the opening in the ring is large and the structures weakened and thinned, I would suggest the use of silver or gold wire, as has been used by Willy Meyer and others with success in the extra method, or a filigree of silver wire as reported by Bartlett in the recent *Year Book of Surgery*. He reports seven successful cases. These silver sutures, or filigree should be placed outside of the peritoneum and the same stitched over it.

In the female the ring may be closed entirely: in the male care should be taken not to constrict the cord.

There is nothing in the anatomical relation of the parts, or in the literature on the subject that in any way convinces that this is not feasible. My experience is limited to one case; and this cannot yet be pronounced a permanent cure; but it is sufficient, I trust, to make others investigate further in this line and determine the value of the method in the three classes of cases that I have mentioned, especially the last two, viz., operations for the release of obstruction produced by reducing hernia *en masse*, or by bands, which form later from the gut having been constricted. When the abdomen is opened for other causes if there is an existing hernia close the internal ring.

## IMPERATIVE SURGERY.

A. B. KNOWLTON, M. D., COLUMBIA, S. C.

About two years ago a colored woman, aged thirty-two, who had spent Saturday in town shopping, was returning to her home, two miles in the country, in a one-horse wagon, accompanied by her husband.

The woman was sitting on the left end of the forward seat eating peanuts from her apron while her husband sat on her right driving at a rapid pace.

Coming in the opposite direction were two one-horse butcher wagons, each pulled by a mule and driven by a colored man. Both turnouts engaged in a hot race. One of these wagons collided with that in which our heroine was seated, resulting in a catastrophe, to the rescue of which I was summoned, and at which I arrived in about thirty minutes.

The woman was lying upon the ground on her left side, covered by a crocas sack. Examination of the patient and queries as to the accident, revealed the following facts: In the collision the shaft of one of the racing wagons flew up, its point punching our patient in the mid-line of the abdomen and just above the pubic bone. The wound included the entire thickness of the anterior abdominal wall, ranging upward and toward the patients left for a distance of seven and one half inches. The fundus of the uterus (which contained a sixth-month foetus) was entirely without the abdomen, and encircled by what appeared to be *all* of the woman's intestines, and all of the omentum protrudable. The prolapsed organs were literally covered with sand, peanuts, peanut hulls, chips and leaves. After emptying the remaining peanuts from the woman's apron it was gathered about the pendant organs sufficiently tight to afford some support, and she was taken to her home. From the amount of shock together, with the complete evisceration and the endless quantity of foreign material adherent to the exposed organs, we felt that the life-saving task was hope-

less in the extreme. Never before had I been made to realize how closely chips could adhere to living omentum.

In a typical southern negro hovel with no light but that which reluctantly emanated from a dingy kerosene lamp and a flickering torch or two, with no antiseptic for the hands but boric acid, with a limited supply of "non-sterile" spring water, and an immeasurable quantity of dirt and filth on every hand we proceeded to do what the result declares was, in modern language, an aseptic operation. After several hours picking of the afore-mentioned variety of foreign material and bathing and replacing the prolapsed organs, we proceeded to sew up the abdomen, and leave the woman to die. "God moves in a mysterious way his wonders to perform,"—the woman did not have a rise of temperature above  $101^{\circ}$ , and after reaction from the primary shock her pulse never exceeded 100 per minute. She went on to a prompt and complete recovery, delivered her baby at full term and has had another baby since.

The patient's chief regret was that she had lost her "bait of peanuts."

If any of my country brethren can beat this for Imperative Surgery, I'd like to hear from them.

Dr. Coward and Dr. Baker of Columbia were associated with me in the case.

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#### A FEW REMARKS ON APPENDICITIS.\*

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T. P. WHALEY, M. D., CHARLESTON, S. C.

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Gentlemen: In considering the diagnosis of appendicitis there are three cardinal points to bear in mind: Acute appendicitis should be diagnosed by pain in the right iliac fossa, tenderness on pressure and rigidity. These three symptoms, in my opinion, are sufficient to make a diagnosis of appendicitis. In about one out of seventeen cases on opening the ab-

domen we may find that they have failed us; but in sixteen cases out of the seventeen, the probability is that the diagnosis is correct. Even if the diagnosis is wrong, in the majority of cases it will be found to be some other condition requiring an operation equally as urgent as the disease diagnosed. Therefore, we can make no mistake in opening up the abdomen on pain, tenderness and rigidity in the right iliac fossa.

Of these two symptoms, the two most important are pain and rigidity, and the most important in my humble opinion is rigidity. This rigidity is nature's effort to protect the inflamed surface beneath the muscles. It is not found in any condition lacking inflammation, therefore, it is the symptom of all symptoms which indicates an inflamed condition beneath—in the neighborhood of the appendix.

Besides these other symptoms, there is the symptom of muscle spasms, which is simply an accessory symptom and an aid in diagnosis.

Nausea is a symptom, which when the physician is called to see the patient, is ancient history, occurring as it does in the very first stages of the disease. Vomiting is likewise an early symptom, but may continue throughout the attack, and is usually present when the physician is called. Constitutional disturbances occur later, according to Murphy, eight hours after the disease is started. They manifest themselves in fever, acceleration of the pulse, etc.

Distention is likewise a later symptom, and one that has nothing to do with the diagnosis of acute appendicitis until after the first 48 hours. Tumor is also a later symptom. Jaundice, which is present in a small number of cases, is likewise a later symptom. Therefore, to sum up the early stages of appendicitis, pain tenderness and rigidity are the cardinal symptoms, by means of which the disease is diagnosed. Given these three symptoms, a surgeon is absolutely justified in performing an operation for appendicitis, provided the condition of his patient warrants it.

So much for the diagnosis.

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\*Read before the Medical Club of Charleston, S. C., June 5th, 1905.



Now in regard to the treatment of appendicitis. Since the days of Fitz, who first described the disease as a disease, and since Worcester, who first laid down the operative indications for appendicitis, the surgical world has been divided more or less as to what should be done in appendicitis—as to whether an early operation should be performed as soon as the diagnosis is made, or as to whether we should wait for a tumor to develop and then operate, or as to whether we should try to carry the patient over the attack and remove the appendix in the interval between attacks. This has been fought out for years, but I think that I voice the sentiment of the majority of surgeons to-day, who have had a large experience with appendicitis, when I say that the earlier the operation is performed the better the chances of the patient, and as Morris Richardson says, "We are by no means sure that the Ochsner treatment will stand the test of time," and he among others, advocates as early an operation as possible. I do not think that Dr. Richardson means that we should operate on cases that are practically moribund, but that we should not wait for localization of the intensity of the inflammation, (abscess formation), but that by careful technic, we can arrest in a large majority of cases spreading of this inflammation, and in many cases save the lives of the patients.

Now in regard to the operation: I beg to say that I prefer for simple cases McBurney's grid-iron incision, and in bad cases an extended McBurney incision as described by Harrington.

As regards the treatment of peritonitis, general or localized, I beg to say that authorities differ. We have Hubbard Price, an arch operator, advocating flushing the abdomen with sterile water or normal salt solution. Price is a man who obtains wonderful results, and we cannot pass him by without giving due consideration to his decision in this matter. On the other hand, Richardson, Kelly, Murphy and others are content with simply sponging off the inflamed surface with normal salt solution or with sterile

water. Mayo thinks flushing practically fatal. Price maintains that the flushings remove quantities of toxine and bacteria that sponging fails to carry away. Other physicians maintain that flushing carries inflammation to the remote corners of the peritoneal cavity.

As regard drainage: Some prefer it in the flank, some in the vagina and others through the large incision, but all advocate the lamp wick drainage, covered by a rubber covering. Glass tubes have long since been relegated to the past.

In regard to the removal of the appendix in very bad cases, cases of abscess formation, the writings of to-day advocate its removal where possible, maintaining that as long as the appendix is left, the focus of inflammation and the disease will progress. In regard to treatment of the appendix in the earlier stage, when we are simply doing an appendectomy, the treatment of the stump is managed in different ways by different authorities. Personally, I prefer slipping back a long cuff of peritoneum ligating and excising the appendix, touching the stump with carbolic acid and then ligating the cuff over the stump. The closure of the abdominal wound should be layer by layer throughout with catgut.

Trusting, gentlemen, that this subject, which is vast in extent, and is getting vaster every day, will be acceptable and will provoke the discussion which I cordially invite. I beg to close.

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#### REMITTENT FEVER.\*

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H. L. SHAW, M. D., FOUNTAIN INN, S. C.

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Remittent Fever is of malarial origin—indeed, it is one of the sub-divisions of malarial fever, and is met with in what are known as malarial districts, in warm climates, but is seen also in a milder form in temperate climates.

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\*Read before the Greenville Co. Medical Society, Aug. 7, '05.

It is sometimes called bilious remittent on account of the gastric disturbance.

Malarial fever is one of the oldest known diseases.

It was once very prevalent in England, but not so now, owing to the fact that the low lands have been cleared and drained, and the home of the mosquito, to a great extent, has been destroyed. The same can be said of the southern part of the United States. Malarial fever that was once prevalent and severe in form is not so much so now.

We are taught that man is inoculated by the mosquito, and one of these little pest can impart the poison to many individuals.

Anders, of Philadelphia, says that in England the peasants used to say, "In such a place there is much fever because it is full of mosquitoes." The same can be said to-day where the mosquito exists.

As regards the pathology of the disease I refer you to those better able to inform you than I am. Suffice it to say there are marked changes in the spleen, liver, marrow of bones, and other parts of the human structure due to poisonous effect of the mosquito on the blood.

These changes are most marked in the spleen, which is at first swollen and soft, but after a prolonged attack becomes permanently enlarged and hard.

The spleen in severe attacks has been known to rupture.

The liver is also markedly affected, but not to the same extent as the spleen.

An individual suffering with remittent fever usually gives us a history of having suffered for a few days with headache, pain in the loins, loss of appetite, with some nausea. Upon examination we find a heavily coated tongue, accelerated pulse, and rise of temperature of variable degree, depending on the individual and the severity of the toxemia.

There are sometimes no prodromes and the disease is ushered in with a chill, followed by a rise of temperature from 102 to 105 F., with a pulse of 100 to 120.

The fever usually lasts until about midnight when it begins to abate, the pulse

slows up, the headache is relieved and the patient gets a few hours of refreshing sleep.

By morning the temperature has almost reached the normal point. We may then have a cold stage followed by high fever in the afternoon, to be continued into the night, when as before, after midnight the fever cools off, these symptoms may repeat themselves for several days or weeks.

There is never a distinct intermission as is the case in true intermittent fever, but only a remission, hence the name remittent fever.

Nausea and vomiting are often prominent symptoms in remittent fever, the vomited matter being a greenish or yellowish color. The urine is diminished in amount, highly colored and high specific gravity.

The diagnosis is made between remittent and intermittent fever by the fact that in the former, while the temperature almost reaches the normal point it does not quite do so, but begins to rise again gradually until it reaches as high a point as on the preceding day, while in the latter the high fever is followed by a profuse sweat, after which the temperature reaches the normal point, and oftentimes becomes sub-normal, which condition exists until a second cold stage, which in turn is followed by fever, sweating and intermission.

The remittent form of malarial fever is of a graver type, usually the intermittent.

Remittent fever can generally be diagnosed from typhoid fever by the difference in the onset, which in the former is more abrupt; from the absence of diarrhoea, which in the majority of cases is present in typhoid; from the absence of tympany, tenderness, and gurgling in the right iliac fossa, which are generally present in typhoid; from the presence of the rash in typhoid on which some lay more stress than I do, as a diagnostic symptom; from the absence of nose-bleed; the difference in the appearance of the tongue; and lastly but by far the most important point, the difference in the temperature chart.

In typhoid there is a gradual rise of



temperature, reaching its height at the end of about one week, to remain stationary for two, then a gradual fall, lasting for about one week until the normal point is reached, while in remittent fever we have a more sudden onset, the fever reaching its height in a few hours or days at most, with a morning remission and evening exacerbation.

The headache and gastric disturbance is more marked in remittent than in typhoid fever.

The entire aspect of the case is worse in typhoid than in remittent fever. Indeed, the prognosis in simple remittent fever is good, only the pernicious cases giving rise to serious apprehension.

It is often necessary to diagnose between simple remittent and typho-malarial fever, which affection sometimes exists in districts where both malarial and typhoid prevail. In this event the presence of typhoid symptoms together with those of malarial would make our diagnosis clear.

As regards the treatment of remittent fever we have a specific in quinine.

The preparation of cinchona used and its administration differ with different physicians and with the peculiarities of the case, some taking one form of the drug better than others, and some having an idiosyncrasy which prohibits its use in any form.

My plan of treating remittent fever is to give an initial dose of calomel, followed by sulphate of magnesia to begin when the fever is lowest, (usually early in the morning). Then I give sulphate of quinine, grains 5 every two hours until 20 or 30 grains have been given, when administration is suspended until the following day. I then continue as on the day before. In the afternoon, if the fever is very high and the headache is severe, I give quinine and phenacetine or acetanilid grains,  $2\frac{1}{2}$  each every two hours until the temperature falls and the head is relieved.

I also administer arsenic in the form of Fowler's solution, 5 drops three times a day after eating.

Keep the patient in bed on light diet, usually liquid.

Keep the bowels open daily with enema or sulphate of magnesia.

Treat special symptoms as they arise.

These cases usually last from one to three weeks, rarely longer.

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#### DIPHTHERIA,—WITH REPORT OF CASES.\*

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W. J. CHAPMAN, M. D., SPARTANBURG, S. C.

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The subject to which I wish to call your attention is that of Diphtheria. I have no original ideas to offer, either on the pathology or the plan of treatment, but this being the season of the year when we are called upon to treat this disease, and the very large per cent. of mortality, are sufficient reasons why we should give it special thought just at this time.

Diphtheria is a disease of antiquity, and has been described by most writers on diseases of children.

Authors differ as to whether it is a constitutional or a local disease. Smith, in his work on diseases of children, says: "It is a law in pathology that those diseases which have or may have a long incubative period, are constitutional." Osler describes it as a specific, infectious disease, characterized by a local fibrinous exudate usually on a mucous membrane, and by constitutional symptoms due to toxin produced at the site of the lesion. He also claims that other contagious diseases have diminished in the last decade, while diphtheria has increased. While this may be true, we believe that the percentage of mortality has decreased under the present plan of treatment, when this has been judiciously carried out.

Diphtheria is a highly contagious disease, and often prevails in epidemics at this season of the year. The Klebs-Löffler bacillus causes true diphtheria, and the bacilli may be carried in various ways

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\*Read before the Spartanburg Co. Medical Society, Sept. 29, '05.

from one person to another: by the clothing, through using the same vessels for drinking water, or in any way through which they may reach a fertile spot for development.

Children between the ages of one and twelve years are most susceptible, but adults are not exempt. Physicians and nurses especially are in danger of contracting it while using the swab or spray in the throats of these little patients.

The pulse is frequent at first, but later in the course of the disease may fall below the average of health, and become soft and compressible as the action of the heart weakens. The temperature is usually from one hundred to one hundred and five; tongue heavily coated; skin at first hot and dry, but after a few days becomes cool with a clammy perspiration. If the larynx and trachea are involved the respirations are notably increased.

The local site of diphtheria is characterized by redness of some mucuous surface, most frequently that part of the membrane that covers the tonsils, and is manifested by a small, slightly raised spot, which is the beginning of the pseudo-membrane. This membrane increases in size and thickness from fresh exudations underneath, and is closely attached to the mucuous membrane, which it penetrates. At first it is white or grey in color, but later on decomposition sets in and it becomes darker. When the membrane is destroyed or removed it will reproduce upon the same spot within a very short while and spread to surrounding tissue. This pseudo-membrane may form in the nose, in the roof of the mouth, or in the larynx and trachea, constituting diphtheritic croup.

#### TREATMENT.

It is generally conceded that internal medicines other than stimulants amount to very little in the treatment of diphtheria, yet few of us would be willing to treat a severe case without internal medication.

The nourishment is of great importance, and should consist of milk and animal broth. I fear that we often make

a mistake in not carefully looking after the quality and amount of nourishment taken by these little patients, and that they die from exhaustion. If the digestion can go on and a liberal amount of nourishment can be taken it will shorten the course of the disease and lessen the mortality.

Stimulants should be given freely as soon as they are indicated. Avoid giving medicines or stimulants in milk, or your patients may become disgusted and refuse to take it as a nourishment. Tincture of iron and small doses of bi-chloride of mercury may be used with good results.

For the local treatment a large number of solutions have been recommended as gargles, swabs and sprays. Löffler's solution consisting of three per cent. of carbolic acid to thirty-six per cent. of alcohol may be used with benefit. However, I prefer peroxide of hydrogen as a spray, being careful not to injure the tissues. I have generally been able to remove the membrane from the nose or throat by this means.

But the sheet-anchor in the treatment of diphtheria is antitoxin. It is necessary for us to decide after examining the patient just when and how it is to be used. I use it as soon as I can after making my diagnosis, giving from two to four thousand units, and repeating if necessary in from ten to thirty hours, until the membrane begins to shrink and the temperature to fall. It should be inserted deep in the cellular tissue. The place selected preferably the hip, should be washed with a strong solution of carbolic acid, the antitoxin inserted and a piece of gauze or absorbent cotton applied with a roller bandage to hold it in place.

The following cases occurred during an epidemic which I witnessed in the fall of 1881 in the northern part of this county. The stricken territory was about eight miles long by four wide, and lay on both sides a large creek. Its duration was nearly seven weeks, during which time there were more than sixty well-developed cases with twenty-six deaths, nine of which were due to diphtheritic croup,



and the others to blood poisoning and exhaustion, or to sequels.

CASE 1. Minnie Q., age nine years. Family history good. I saw this patient with Dr. Landrum first, on the eighth day. Both tonsils, the roof of the mouth and posterior nares were covered with a thick brown pseudo-membrane. The adjoining mucuous membrane was a dark red. Temperature 100; pulse 138; breathing altogether through the mouth. On the ninth day there was some blood oozing from the nose, and she spit up mouthfuls of dark blood. Temperature 99; pulse weak and very fast, and the pseudo-membrane dark. I was called early on the tenth day and found her bleeding freely from the side of nose or cheek about one-half inch below the right eye. She was delirious until after noon, when she became comatosed and died early in the night.

CASE 2. Lee F., male, six years of age. Diphtheria on both tonsils. On the eighth day all traces of the pseudo-membrane had disappeared; on the tenth he was allowed to be up, and by the thirteenth day was playing about the yard. On the morning of the fourteenth I was there to see others in the family suffering from the same disease, when my attention was called to the heavy breathing of this boy. He was unable to swallow milk or water. His temperature was subnormal, and pulse sixty to the minute. He complained of his head swimming. This grew worse, and his pulse dropped to 40 by noon. At four P. M. it had fallen to 20, and death soon closed the scene.

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#### DISEASES OF THE ACCESSORY SINUSES OF THE NOSE.\*

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BY W. PEYRE PORCHER, M. D.  
CHARLESTON, S. C.

At the request of the Editors of the *Journal of the S. C. Medical Association* this article was prepared as a review on

\*Read before the Medical Society of S. C.  
Oct. 2, 1905.

recent work in Rhinology. At the last meeting of the American Laryngological Association, held in Atlantic City, an extremely interesting Symposium of eight papers was read, followed by a most illuminating discussion by many of the ablest men in this department in America.

Acute and chronic disease of the maxillary antrum, the frontal, the ethmoidal and the sphenoidal sinuses were discussed by such men as R. C. Myles, C. G. Coakley, J. W. Gleitzman and T. P. Berens of New York, and J. O. Roe of Rochester, J. W. Farlow and George A. Leland of Boston. The limits of this paper make it impossible to give more than a bare synopsis of the papers and even less of the prolonged discussion and variety of opinions expressed which followed them. Many of the most obscure diseases involving sequelae which cannot be accounted for in other ways originate in these sinuses. The etiology, diagnosis and surgery of purulent involvement of these cavities requires an amount of practical experience, skill and ability in my opinion exceeding that of the surgery of any other part of the anatomy. This is proved by the obscurity by which these so-called empty cavities are surrounded, and the extreme variety of opinions held concerning the proper treatment of them. On this account I have deemed it worthy to quote some of these opinions and experiences of others in order that my own views may not appear to be biased by want of the larger experiences which others may have obtained.

In the symposium on disease of the maxillary sinus two papers were read, one by R. C. Myles, of New York, and the other by Geo. A. Leland, of Boston. A very wide divergence of opinion is held in regard to the proper surgery of the maxillary antrum,

"Like the torturing ancient enigma, o'er which full many a brain hath long pondered."

Dentists, to whom most of these cases occur, believe that the disease is always due to caried teeth, and hence operate by alveola puncture. Rhinologists, per contra, have urged, and still urge, that these cavities are little more than overflow cav-

ities from the nose and as such are affected by any inflammation, general or local, affecting these organs and therefore that thorough investigation of them should be made through the canine fossa or through the inferior meatus in the nose, in order that all septal partitions, polypi, supernumerary teeth, purulent accumulations, etc., may be removed.

At this late date, however, Dr. Myles writes as follows:

In the writer's opinion, radical surgery should be employed:—on nearly all cases of exposed bone necrosis beneath the periosteum and at the roots of the teeth; on all cases of extensive polypoid changes in the mucosa—chiefly indicated by a very large and protruding lip of the hiatus semilunaris, associated with chronic ethmoiditis; on all cases of osteomyelitis—which is usually evidenced by a discharge of a peculiar offensive wine-colored secretion which upon irrigation fills the returning fluid with small black particles of putrid debris of blood. Nearly all cases of neoplastic growth require extensive radical surgery. The earlier and more complete the surgical procedures, the more favorable the results will be.

It is in the long-standing cases of purulent and muco-purulent discharge, with all their varying degrees of activity that we are often baffled as to the conscientious course to pursue. Foul-smelling pus of a mealy character when mixed with water, is not a symptom that always demands radical surgery. The writer after having performed several hundred operations through the canine fossa and malar ridge and more or less thoroughly curetting the antral walls, has practically abandoned the procedure and has on several occasions warned the profession against over-curettage of the edematous membranous walls, unless provision is made for a permanent opening from the antrum into the nose through the inferior meatal wall, in order that drainage and free ventilation may take place, while the walls denuded of the internal vestments may at best slowly cicatrize and in a measure reproduce themselves.

In regard to the comparative results of conservative and radical methods of treatment:—Radical treatment is supposed to remove the pathologic condition as well as the cause or root of the disease, and to leave no cause for a future diseased condition. I have experimented for years with conservative and radical methods and have tried to be fair to the patients and to the respective methods. The irrigation method through the normal opening was carried out during a series of years on certain classes of cases, some on account of the demands of the patients and others for scientific reasons. A number of patients were cured but the treatment was too slow and too uncertain to merit more than occasional favor. As above stated, the operation through the canine fossa and malar ridge has been abandoned in the ordinary suppurative cases. Such good results have been secured in this class of cases by a conservative operation that the writer, in almost every case, uses it as a curative procedure or as a preliminary operation to the canine fossa one.

This conservative treatment consists of an operation with curved chisels which cut going in and coming out, with the use of the rongeur forceps, and with the occasional aid of the electric trephine. As much of that part of the antro-nasal wall which is situated within the inferior meatus is removed as possible, and in certain cases it is best to remove a part of the inferior turbinate. After irrigation the cavity is carefully curetted with the malleable-handle curettes and packed with  $\frac{1}{2}$  inch iodoform gauze. The cavity is irrigated through this opening until the discharge practically ceases. So far, the results in a series of cases after this procedure have been better than those of the other methods.

Dr. J. Payson Clark, of Boston, said:—There is one point in regard to empyema of the antrum which has not been touched upon in the papers or discussion which seems to me should be mentioned, and that is that there are two distinct forms of empyema as regards etiology; one is the empyema arising from some disease of a tooth, and the other is the empyema arising from infection through the nasal cavity. In my experience those cases arising from a bad tooth are very amenable to treatment. I have in mind one case where a purulent discharge from one nostril had existed for seven years. On the removal of a diseased tooth and washing out for three weeks twice a week it was entirely cured. I think one point wants to be remembered, that if a tooth is the source of the infection it acts very much as a foreign body, but when it is removed the case gets well. Another point regarding the radical or Luc operation on the antrum and packing the antrum afterwards. I used to pack it with gauze, but I found that it caused a great deal of pain and discomfort, and I could not see there was anything to be gained by it, so in the operations I have done in the last two years I have not packed the antrum at all. I have opened the canine fossa, explored the antrum, removed the thickened membrane, made a large opening into the nose, then allowed the wound in the cheek to close. The patient has been much more comfortable after the operation, and I have not been able to see that the result was not just as good as with packing.

Dr. Geo. A. Leland also advocates conservative treatment. He reports the case of an old lady, however, whose antrum was filled with polypi, although it was perfectly clear upon transillumination, and who only got relief after the radical operation through the canine fossa. He advises an extension of the highatus highmoriani to be made under the anterior end of the middle turbinate. The opening should be so large as to admit of thorough cleansing through an irrigation tube daily. He claims far better results from this than from the radical operation through the canine fossa. In my opinion by far the most frequent of all the diseases of the accessory sinuses is acute and chronic ethmoiditis. In fact acute rhin-



itis and ethmoiditis may almost be regarded as synonymous terms, since these cells are affected by almost every inflammation affecting the nose.

The ethmoid cells constitute the middle section in the chain of air spaces extending from one frontal sinus around through the sphenoidal cells to the other, and they are divided themselves into anterior middle and posterior ethmoids. The diagnosis and treatment of disease of the ethmoid cells is more easy than either the frontal or sphenoidal because they are much more accessible, but purulent disease of these cells require the utmost skill and perseverance, as they cannot be reached externally without causing marked disfigurement of the face, and in curetting them there is constant danger of puncturing the orbital cavity. This accident has happened to some of our best surgeons, and I have myself produced an emphysema of the lower lid more often than once, in doing the same operation. In fact, there is no absolute guide by which we can be guarded against it, and it was only by the fact of the emphysema that I knew I had arrived at the danger line. With the free use of cocaine and adrenalin the bulla ethmoidalis may be opened and curetted and in some cases the pus discharge may be stopped.

Roe of Rochester says, "Many so-called ozaenas and purulent conditions of the accessory sinuses result from early neglect of catarrhal conditions of the ethmoidal cells." He quotes a case where the foeter of breath rapidly disappeared after thorough curetting of the cells, and said:

This case is but a type of such cases, and the more of them I see, the more I am convinced that so-called ozaena is nothing but a foetid discharge from some of the Accessory Sinuses, usually the Ethmoidal.

Disease of the frontal, maxillary and even the sphenoidal sinuses is usually detected and properly treated; but when hidden in the ethmoid cells it frequently goes undetected, causing a slow necrosis of the cells and the consequent odor, and also the atrophy of the surrounding soft parts arising from the associated disturbance of nutrition.

The foul discharges and crusts which so mysteriously appear on a smooth unbroken mucous membrane, the cause of which it has been claimed "no fellow could find out" have been attributed to

perversion of the secretions of the mucous glands in some unaccountable manner, to special discrasias and to various other causes. These will be found in nearly all cases, I believe, to have their origin in some of the ethmoid cells, although perhaps too deeply hidden to be readily detected; and it is only by radical methods of treatment that the cause of this trouble can be reached and cured. This is illustrated by many cases that I could cite did time and space permit.

Increasing familiarity with the cellular structures of the nose leads us to recognize the early stages of diseased conditions, which if dealt with in a radical manner, as is practiced in disease of the mastoid antrum and cells, will not only prevent the establishment of a chronic disease of these cavities, but will often forestall conditions, as in the case of chronic aural diseases, that may lead to serious consequences. "A fatal case of necrosis of the sphenoidal and posterior ethmoidal Cells," has recently been reported by Whitehead of London.

A woman, aged 40, who had had, for several years, a chronic catarrhal condition about the upper portion of the nasal fossae, with much discomfort about the nose, contracted an influenza causing a severe inflammation of the turbinated tissues, attended by a profuse discharge, which soon became purulent. She had also severe pain in the side of the face and distress about the bridge of the nose and frontal headache. By contracting the tissues with Adrenalin and with the aid of the probe, the discharge was traced to the ethmoid cells, the bulla ethmoidalis being markedly distended. This cell on being opened was found unusually large and filled with a mucopurulent material containing some streptococci. The surrounding ethmoid cells in communication with this cavity were also involved; these were freely opened and drained, when the nasal disturbance subsided.

The author very truly says, "The importance of treating chronic nasal suppuration is still not fully realized by our profession at large. A persistent discharge from the nose is regarded with the same slight interest that a chronic otorrhea attracted a few years ago; nevertheless, the present case illustrates the danger of leaving untreated a suppuration in close proximity to a vital organ."

Orbital abscess and cerebral symptoms sometimes complicate ethmoidal abscess and urgently demand the most radical measures for their relief.

Many cases of persistent headaches, facial neuralgia, migraine and tic-douloureux caused by pressure within the ethmoid cells have come under observation, and the patients were cured by operative removal of this intra-cellular pressure. In some cases, this intra-cellular pressure may be caused by purulent or other accumulations confined by the occlusion of the ostia; in others, it may result from intra-cellular polypoid or other growths distending the cell; while in some others, it may be purely bony, from osseous thickening resulting from injury and a chronic non-purulent inflammation of the cells.

Facial neuralgia is so frequently caused by intra-nasal pressure in the region of the middle turbinate that treatment of the pain should never be instituted without carefully investigating the ethmoid region. This must often be done with the probe, sometimes requiring the use of cocaine, for by simple inspection only the condition of the

parts and points of pressure cannot be specifically ascertained. In purulent cases, the appearance of pus is an aid in directing us to the diseased region; but as the pain in most neuralgic cases is associated with a condition of catarrhal thickening of the tissues, physical exploration for such condition is necessary.

I wish to mention one point in the etiology of sinus disease and especially in regard to the method by which infection is frequently forced into these cells. This is by the forcible blowing of the nose during a coryza, or while infected with an influenza, or whenever pus is lodged in the nose. By this means, and especially if the pressure is increased by closing one nostril, infection frequently is forced into normal cells that otherwise would remain healthy.

One or two points in regard to the radical measures resorted to in dealing with diseased ethmoid cells, and I am done. The use of the ring knife or sharp curette is not only illadvised, but, in many cases, positively dangerous, when used in proximity to the lamina papyracea or os planum or the cribiform plate. It is in cases of polypoid growths within the cells only, that the use of the curette is admissible; for, in the case of simple suppuration of the cells, perfect drainage is the desideratum, and not the destruction of the mucous membrane. The curette tears more readily than it cuts, and, therefore, the danger of laceration of the deeper structures is apparent.

John W. Farlow, M. D., Boston, said:

Of symptoms which call for operative interference, one of the most common is headache, which is sometimes referred to the back of the occiput. This may be due to a complication with frontal disease, from inability of the latter to drain itself on account of enlargement of the ethmoidal bulla filling up the hiatus semilunaris. The headache may be caused by a pushing of the middle turbinate against the septum or by the development of one or more large cells in the turbinate, thus causing painful pressure against the septum. The presence of polypi, the result of ethmoidal disease, may serve to cause retention of secretion, pressure and headache. In my experience, such cases have not been uncommon, a small polyp, even granulation tissue or swollen mucous membrane sufficing as an obstacle.

The eye is often involved where there is ethmoidal suppuration, especially if there is marked retention of secretion. Swelling of the lids or conjunctiva, troubles of vision, displacements of the eye, abscess of the orbit, all these manifestations are to be laid at the door of severe ethmoidal disease and require thorough treatment. Meningeal inflammation, acute or chronic, has been noted in some instances.

Tertiary syphilis not infrequently attacks the ethmoid, showing itself by suppuration, crusts, necrosis and pain. The pus may find exit externally near the root of the nose and external operative procedures may be necessary in order to remove the large mass of necrosed bone.

The sense of smell may be much impaired or entirely destroyed in the nostril where the ethmoidal disease exists; but, unfortunately, the methods of treatment necessary for removing the diseased structures which cause impairment of the olfactory sense cannot leave the nerve filaments

in condition to resume their formal function. An attempt should, however, always be made to respect, as much as possible, the region where this important sense is situated.

Suppuration, causing a long continued flow of pus into the middle meatus, showing itself either anteriorly, or posteriorly in the post nasal space, with resulting pharyngitis, laryngitis, asthma, etc., and not amenable to ordinary treatment, may require surgical procedures for its abatement.

As a result of the irritating local action of the pus, the development of polypi in the middle meatus and a severe polypoid degeneration of nearly the entire middle turbinate may be so rebellious to all ordinary snare and curetting operations that removal of the ethmoidal cells and the turbinate may be necessary.

If the ethmoidal secretion is in such relation to the opening into the antrum that the latter acts as a reservoir for the pus, an opening into and removal of the ethmoidal cells may be advisable in order to cure the secondary antral symptoms.

We may summarize the symptoms of ethmoidal diseases calling for surgical intervention: Severe or long continued headache, disturbances of vision, displacement of the eye, orbital abscess, inflammation of the meninges, syphilis and forms of necrosis, obstinate polypi, especially when combined with polypoid degeneration of the middle turbinate, frontal disease caused by ethmoidal obstruction, pus in the antrum of ethmoidal origin, severe or obstinate forms of ethmoidal suppuration with pus flowing into the post-nasal space causing laryngitis, bronchitis, asthma, or other disease of the upper air passages.

An advantage possessed by the ethmoid cells over the antrum, frontal and sphenoidal sinuses as regards treatment, is that the former are accessible by intra-nasal procedures, and they can be opened, curetted, drained and treated without external openings. It is true that when the upper part of the nostril is narrow from a general narrowing of the nose or from a bent septum, it may be difficult to gain access to the cells; but, usually, after removal of the anterior end of the middle turbinate, (which is often diseased at the same time) we are able to penetrate the cells, break down the cell walls, give vent to the pus and curette the secreting tissues. In my own experience, I have found almost no cases where other than persistent, perhaps long continued intra-nasal treatment has seemed to me to be advisable.

In every instance the crust formation which is so difficult to prevent is directly attributable to incomplete removal of the ethmoid cells. Lack of space and time prevents me from giving a synopsis of the discussions on the frontal and sphenoidal sinuses; suffice it to say that the sphenoidal sinus being located further back than either of the others is of course the most difficult to diagnose and treat. Unless the nose is unusually roomy and the space under the middle turbinate is quite large, it is necessary to remove the ante-



rior end of the bone in order to enter the ostium.

T. P. Berens, of New York said: It is rarely indeed that the probability of disease of the ethmoid cells can be excluded when making a diagnosis of sphenoidal disease, and also that judicious treatment of encroaching disease of the ethmoid cells will prevent the necessity of operative treatment upon the sphenoids in cases of pyosinus of the latter. He claims that he gets the best results from opening the sphenoid through the maxillary antrum and the ethmoid cells.

Of course where it is possible to differentiate between purulent involvement of the frontal and sphenoidal cells the canals leading to them should be thoroughly opened and their walls curetted. It has been found, however, as Dr. Berens stated, that thorough curetting of the ethmoid cells gives such free drainage to the other cells that operation directed alone to them often becomes unnecessary.

J. H. Bryan, of Washington, speaking of frontal sinus operation, said:

With regard to the frontal sinus operation, in 1890 I did my first sinus operation, and I tried it by the open method. I treated that case for one solid year, operating on it twice. The parts closed so that it was impossible to make any local applications through the external wound. I was unduly timid at that time and did not remove enough of the ethmoid, although I did make a sufficient passage from the fronto-ethmoid region to bring about what I supposed was sufficient drainage. Unfortunately, the granulations were weak and broke down, but the external wound closed so that it was impossible to keep the parts open. So that is not a method by which you are positively sure you can bring about a cure after operating even a second time. I wish to take exception to the statement that it is impossible to cure these cases except by the open method. I have cured the majority of my cases by the closed method. I have tried every method known to-day except the Killian. Positively I do not understand this operation. I have done it several times on the cadaver, but when I see cases going around as in Europe, showing a furrow, sufficiently deep to put your forefinger in, and at the same time cannot feel sure then that a cure has been accomplished, I cannot bring myself to operate by this method. I saw one case of Killian's which had to be operated on three times, so that is another evidence that the Killian method is not a positive cure. I have resorted to the so-called Caldwell-Luc method in the majority of my cases and all are well to-day.

One of the most interesting chapters in the study of diseases of these sinuses is the effect which they have upon the eye and it has been in recent years only that this has been clearly recognized.

In the issue of the *Journal of the American Medical Association* of Sept. 9th, 1905, appears a very comprehensive article by W. C. Posey, of Philadelphia, on "The Ocular Symptoms of the Accessory Sinuses of the Nose," in which he states that orbital abscess is usually secondary to these sinuses; that displacements of the globe may be occasioned by encroachment of the orbit, by a distended sinus, and that blindness may result from an involvement of the chiasma through the roof of the cavity or by an implication of the optic nerve as it passes through its foramen in the sphenoid, as a consequence of the inflammation in the cells within that bone.

The earliest symptoms of disease of these sinuses are often ocular and are diagnosed as eye strain and are sent to the oculist for refraction. Strange to say, the correction of these errors of refraction do appear in many instances to correct the underlying condition, or correction of the refraction keeps the other symptoms in abeyance. It has even been thought that the use of atropine may have brought this about by drying up the secretions. In many instances, however, no such desirable result is accomplished, but the disease in the nose becomes even more intractable and the patient endures prolonged suffering and discomfort. The involvement of the optic nerve as a consequence of ethmoidal or sphenoidal sinusitis may vary from a simple oedema to an active retrobulbar inflammation. In fact, it may be said that in all cases where the nerve is affected, careful search should be made for disease of one or other of these sinuses.

It must be remembered, however, that optic neuritis may arise in individuals with sinusitis from other causes, such as alcohol, tobacco, etc. One of the chief characteristics of optic neuritis from sinusitis is its unilateral character, because it is very rare for both nerves to be af-

fects in the optic canal by inflammation of both sphenoidal sinuses. The location of an abscess pointing externally is of value as indicating the particular sinus affected. Absence of the frontal sinus tends to perforate at the middle of the upper lid or at the superior internal angle of the orbit. Those due to ethmoiditis at the lower inner angle. Disease of the sphenoid as a rule manifests itself by an early involvement of the optic nerve. Ethmoid disease produces asthenopia by interference of the intra ocular muscles, conjunctivitis, etc. Inflammation of the antrum of highmore affects the eyes less than any other of these sinuses but may produce upward dislocation of the globe and retrobulbar optic neuritis from infection through the lymphatics.

Disease of the lachrymal apparatus is produced more frequently from inflammation of these sinuses than from any other cause. This is especially the case when an empyema of one of the sinuses empties itself into the sac or produces obstruction of the canal from inflammation of the surrounding structures. The differential diagnosis in this disease can only be made by finding the diseased sinus in the nose. Persistent blepharitis and inflammation of the lids is no uncommon accompaniment of inflammation of the accessory sinuses. In fact, there is no part of the eye which may not be affected. Ziem even claims that cataract may result from it, and states in support that he found opacities in the lenses in many cases of suppurative diseases of the nose, and adds that in a number of cases of unripe cataract he improved the vision by treating the sinuses. Kuhnt also claims that he has seen vitreous opacities clear up after the same treatments.

Perhaps the most important among the direct and indirect results of disease of the accessory sinuses of the nose is asthenopia and the refractive errors. It is well known that the form of the orbit determines in a large measure the shape of the human eyeball and Kuhnt has proven that facial asymmetry may result in human subjects from a deviated septum, and hence purulent accumulations may so

modify the relation of the parts as to alter the shape of the ball and produce the short or long, hyperopic or myopic eye. Of course headaches of various forms and degrees of intensity frequently occur. Other constitutional symptoms, such as malaise, fever, gastric irritation, epilepsy, melancholia, delirium, abscess of the brain, etc., etc., are a natural result of severer types.

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#### DISCUSSION OF DR. PORCHER'S PAPER.

DR. KOLLOCK: Mr. Chairman, Dr. Porcher's paper is upon a very important subject, not only to the specialist but to the general practitioner. There are so many of these cases which occur and which are overlooked, as one would be led to infer from what he has said. The frightful headaches they produce are not always locating where the trouble is, and all of those things make it a most important subject. There is nothing, practically, for me to say in addition to what he has said. I think, though, that some cases of what is called trouble with the lachrymal sac are simply diseases of the ethmoidal cells, which have broken through, and they have been diagnosed as diseases of the lachrymal sac. I may be wrong in this. I have sometimes seen it where it was impossible to say where the trouble began, but I have seen cases where the lachrymal duct appeared to be perfectly patent and through which a probe passed, but the tissues surrounding the sac were diseased, and a probe could be passed through into the ethmoidal cells, and while the disease in this case may not have begun in the ethmoidal cells, they might have been involved by necrosis of the bone; I believe there are some cases in which this condition takes place.

DR. PORCHER: I have nothing further to say, except that I think Dr. Kollock is right. I think frequently, especially in syphilitic disease of the lachrymal duct, the ethmoidal cells are almost universally involved at the same time, and if the nose is treated internally, instead of depending upon an outside opening, we would get better results. Dachryo-cystitis is probably, as Dr. Kollock is aware, one of the most intractable diseases which oculists have to contend against. S. Theobald, of Baltimore, claims that the reason such universal failure is met with in opening up these cases of dachryo-cystitis is because the opening is not made large enough. He has advocated such enormous probes that you would hardly think they would enter the lachrymal duct at all,—you would suppose that if a point of one-eighth to one-quarter of an inch were forced through it there would be trouble. These probes are introduced, and it is my belief that if the ethmoidal sinus were opened and the cause removed, it would not be necessary to pass such a big probe.

The chief interest about this matter is the obscurity with which these sinuses are surrounded; it is so difficult to diagnose a majority of them. So frequently cases producing violent and prolonged headache, lasting sometimes ten or fifteen years, are passed over with only temporary relief



from medicaments and have nothing permanent done for them. I believe if on examination the cause were found, the patient would be cured, and not allowed to go on until the patient almost wanted to commit suicide for want of relief. In cases of facial neuralgia you will see many of these men suffering because of failure to treat the disease in the nose. It seems scarcely logical to cut out a nerve center for the relief of the neuralgia without finding the cause of the trouble first. It is better to remove the cause of inflammation than to cut out the gland itself. Not only has the sphenopalatine ganglion been removed for this disease, but also the gasserion ganglion; which is a very dangerous operation and from which on frequent occasions the patient has come within an ace of death. I had such a case that had been operated on four times. The sphenopalatine ganglion and the gasserion ganglion had both been removed and all the teeth extracted. After that he came to me, and told me that not one of the men who operated on him had made an examination of the nose to find the cause of the trouble. Such a statement is hardly credible. You would hardly believe that a set of intelligent men would operate on a man which came so near killing him and never look in the nose to find the cause of the trouble. That man had had to have the carotid artery tied, and a gallon of salt solution injected in this vein, in order to save his life. I thought there was sufficient pressure in the nose to cause the trouble, and I operated on him and he got relief for several months, but he would never allow me to give him chloroform, so as to open the antrum and pass my finger in and get at the trouble.

Another was an old man whose wife thought he never would be in condition to work again, because of this fierce pain from facial neuralgia. He was operated on, and I found identically the same condition. That has been about three years ago, and he has been working steadily ever since. While he has had some return of the pain, he has been able to resume his business, and I was very much pleased with the result.

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## PROCEEDINGS OF COUNTY SOCIETIES.

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### Medical Society of South Carolina, Charleston, S. C.

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Regular meeting held at Roper Hospital, October 2nd, 1905, at 8:30 p. m.

After the transaction of routine business, Dr. Rees was called to the Chair, and the President, Dr. W. P. Porcher, read an instructive and interesting paper on "Diseases of the Accessory Sinuses in the Nose," being a review of recent work on that subject.

(See paper and discussion elsewhere.)

## Medical News.

DR. REES: I will report very briefly a case operated on some time ago under a mistaken diagnosis, which was rather rare and of some interest.

This case was that of a nurse in the Training School who started off with an irregular illness, complaining of digestive disturbance with rather slight temperature which she had had two or three days before I saw her. This temperature ran on, varying somewhat, resembling typhoid, for several days; examination made of the blood was negative on three separate occasions. She developed quite an acute pain in the right side, about which I felt some anxiety, which continued from Saturday until Monday, increasing all the time, and on Monday the temperature ran higher and the pulse increased in rapidity; the area of tenderness on the right side was increased. The symptoms seemed to indicate a rapidly progressing appendicitis, and I made an operation on her. In opening the abdomen, the appendix was readily found and brought out, and was very little inflamed.—so little that it was impossible to tell whether there was anything the matter with it at all; but in the neighborhood of the appendix, in three or four inches above the ilio cecal valve, in the caecum, there were three enlarged glands that had gone to the extent of almost breaking down into a gangrenous mass, dark blue, and looked extremely angry. Inflammation was limited to these glands, not extending to the bowel, and the bowel above was not inflamed. I took these glands out carefully, some little distance from the inflamed surface, resecting through perfectly healthy structure. The patient improved markedly; temperature became normal, and the pulse fell to about 80. The trouble seemed to be cleared up by the removal of these glands that were so rapidly undergoing changes.

After five days of normal temperature she developed a temperature which was hard to account for, and which ran along for three or four days, gradually increasing in the evening. Another blood test was made, and the reaction was then very positive and promptly so. This case ran along through a rather mild typhoid, and recovered absolutely.

DR. CORNELL: I would like to report a case of Uncinariasis under my care, simply to call attention to the marked degree of anaemia that has taken place.

A small boy at the cigar factory came to my office a few days ago, looking the picture that you see in these cases. I made him return next day with a specimen of his stool, and finding the eggs in it, sent him home with a prescription of thymol. The next day I took the blood, and found it, as I thought, below 5% haemoglobin. The boy was very puffy and waxy in appearance; his lips bluish and his heart very irregular and weak. After seeing him that morning, his mother sent for me about 2 o'clock, and I found the boy had intense pain; his pulse had gone to pieces pretty much, and I had to stimulate very freely. But the degree of anaemia was the thing I thought very important, showing how it can develop. I think in these cases the earlier the treatment is started the better.

DR. PORCHER: How did you administer the thymol?

DR. CORNELL: I gave the boy two powders, of twenty grains each. First, I wrote a prescription for salts, to be given at night. Some army man, who has done a great deal of work in Porto Rico, claims that oils or alcohols cause the thymols to be changed into carbolic acid, and we had one case at the hospital some time ago that apparently resulted from that,—so I warned them against alcohols. Finding his bowels had been running off very well, I did not give him the salts that morning, but gave him those two powders of thymol in plenty of water, the second powder two hours after the first, and then, if the bowels didn't move, left directions to give him salts. He has done nicely. This disease is fairly easily recognized, and search for the eggs should be made in any case of marked anaemia. After the lapse of a week an examination should be made again for the eggs, and if present the treatment with thymol should be repeated. The patient should also be put on iron. That is about all the treatment there is.

DR. PORCHER: I have to report a case of what appears to be epithelioma of the sublingual gland in a man 75 years of age.

I have not been able to get a report from the pathologist, but take it to be that. I operated on it about a week ago, and there has been some return. I cauterized it very thoroughly after the operation, and have done so again. I found a decided return of it again this morning on the left hand side, and I cauterized it very thoroughly, and am in hopes of being able to keep it down.

The patient is quite an old man, about 75 years of age, and I did not find the jaw-bone infected, as I expected, nor the glands tender, therefore I didn't find it necessary to take out the whole, or even a part of the tongue, or even a portion of the jaw-bone, but removed the gland under the tongue, and cauterized it severely with an electric knife. I hope to be able to keep it down by that treatment, and will report it again so as to have the diagnosis cleared up.

There being no further business, the meeting, on motion, adjourned.

## NOTES AND REVIEWS.

### Surgery.

T. P. WHALEY, M. D.

#### INJURIES OF THE UTERUS DURING GYNAECOLOGICAL OPERATIONS.

In the *Amer. Jour. of Urology*, Sept., 1905, Charles Green Anston of Boston sums up a lengthy and able article on "Injuries of the Uters During Gynecological operations" as follows:

During a laparotomy the greatest care must be taken in order to avoid injuring the ureter, and the abdominal incision should not be closed until one has made certain that no operative lesion exists. If the ureter has been tied off, the ligature should be loosened and each vessel should be

ligated separately. If the ureter has been incised, the opening should be closed by sutures, when it is not larger than one-third of the circumference of the canal, and this should be done after a ureteral catheter has been inserted, because by this means the opening can be closed more securely and the danger of stenosis is thus avoided. On the whole it may be said that the use of immediate suture depends entirely upon the direction of the opening in the ureter, because if this is oblique it is easier to do than if one is dealing with a transverse section, and the outcome is apt to be far more favorable. If the wound is too large, or if the ureter has been completely cut through, the technique will then depend upon the position of the injury. If this has occurred near the bladder, the renal end of the ureter should be implanted into the latter organ, while, if it is situated higher up, so that the ureter cannot be brought down to the bladder without tension, anastomosis will have to be resorted to. This can be done end to end, after having obliquely cut the extremities, or by invagination of the upper into the lower end, or by lateral implantation. Should all these methods be impossible on account of the resection of a portion of the ureter, implantation of the injured ureter into the normal one must be tried and when this is impossible, nothing is left but nephrectomy, which, as we have already pointed out, should be, if possible, secondary.

#### PENETRATING WOUNDS OF THE ABDOMEN.

In concluding an excellent article on "Penetrating Wounds of the Abdomen" (*Journal Amer. Med. As.*, Oct. 7th, '05), Dr. Dandolph Winslow of Baltimore summarizes his cases as follows:

Total number of undoubted penetrating wounds of the abdomen treated, 29. Cases in which laparotomy was not done, 5; of which, one patient recovered, 20 per cent., and four patients died, 80 per cent.

Penetrating wounds of the abdomen, in which laparotomy was done, 24; of these, 15 patients recovered, 62.5 per cent., and 9 died, 37.5 per cent.

Penetrating wounds of the abdomen, with perforations of the hollow viscera, 20; 11 patients recovered, 55 per cent., 9 died, 45 per cent.

Gunshot wounds with perforation of the hollow viscera, 16; 7 patients recovered, 43.75 per cent., 9 died, 56.25 per cent.

Stab wounds with perforations of the hollow viscera, 4; 4 patients recovered, 100 per cent.

Penetrating wounds in which various lesions were found, but without actual perforations of the hollow viscera, in which laparotomy was done, 4 patients, all of whom recovered.

While the cases here enumerated are too few to prove much, they are nevertheless suggestive—without operation 80 per cent. of the patients died; with operations, 62.5 per cent. recovered.

#### DIAGNOSIS OF RENAL CALCULUS.

In the *N. Y. Med. Journal and Philad. Med. Journ.*, Feb. 4, 1905, Johnson, after discussing the subjects in a general manner, takes up the technique of Skiagraphy and comes to the following conclusions:



The positive diagnosis of kidney stone by the X-ray is reliable and of great practical value.

The negative diagnosis of kidney stone by the X-ray is reliable and valuable up to a certain limit.

If pictures of a proper quality are obtained, calculi of oxalate of lime and phosphates can be excluded. Pure uric acid calculi cannot.

Pictures of a proper quality can be obtained with ease in children and slender adults of both sexes.

Such pictures can usually be obtained by repeated trials, in well nourished adults.

When patients are unusually stout, when the abdomen is very thick and the buttocks are large, the conditions are extremely difficult, and only occasionally will a satisfactory result be obtainable with the present form of apparatus.

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### Materia Medica and Therapeutics.

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J. L. NAPIER, M. D.

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#### PNEUMONIA.

There has been far too much "prescribing for pneumonia," and too little accurate fitting of remedies to the diseased conditions presenting themselves in the cases that come before us. Dr. Carrington wisely alludes to the use of strychnine which is far from being a remedy for pneumonia, and is capable of doing great harm when given without judgment. In the hyperemic stage, when the abnormal vasomotor condition constitutes practically all the disease that then exists, the powerful action of strychnine in contracting the paretic pulmonary capillaries is of great importance; and after the alimentary canal is emptied and disinfected the tumultuous heart action sedated, and vascular tension elsewhere relaxed by aconitine and veratrine, the attack may be dissipated so quickly that the physician trained quickly in the stock ideas of the text books, doubts that he really was dealing with a case of pneumonia. But later, when the lung is solidified by an extravascular effusion, the vasomotor conditions are less prominent and the function of strychnine and digitalis is limited to the need of the heart for support. This position I believe is impregnable.

One further point I wish to make is that this method of applying the remedial agents to conditions, instead of to diseases by their names, is not only incomparably more effective, but is much easier than the ordinary method. This is necessarily the case, since it involves a study of nature instead of art; the study and treatment of the case before us instead of that typical one pictured in the books, with more or less accuracy, but which is, at the best, only an average of the possibilities presenting in all cases, but which may not be realized in any one case. This may be illustrated by an experience the writer had in obstetrics: During one year he attended 54 cases. The average period of gestation was exactly as given in the text books, 9 months and 5 days, but in point of fact not one of the 54 cases came off on exactly the average day.

—(Extracted.)

#### OBSERVATIONS ON THE DIAGNOSIS AND TREATMENT OF HERPES ZOSTER.

To the *New York Medical Journal* of June 17, 1905, Robinson contributes a paper, at the close of which he recommends the following plan of treatment:

Rest, attention to the general nutrition of the body, the combating of microbes, the application of cold over the affected ganglia, a coal-tar preparation for the toxemia, and codeine and bromide of potassium for pain not controlled by the antipyrin. Local treatment consists in aseptic and antiseptic measures. If the case is seen at a very early stage, the affected area can be disinfected in the usual manner by soap and alcohol and then painted with flexible collodion and when convenient an antiseptic gauze applied. If seen later, when vesicles are changing in color, an ointment of boric acid and bismuth subnitrate, and avoidance of soap and water, meet the indications. Later ichthyol can be added to the ointment, or an antiparasitic preparation, as the ammoniated chloride of mercury ointment with rose ointment, to which bismuth may be added, and also ichthyol.

For the persistent neuralgias following zoster, anodynes and the faradic current or x-ray may be of some curative value, but on account of probable structural changes in the nerves and connective tissue of the ganglia, the condition is very rebellious to usual methods of treatment for neuralgia. Tonics, such as phosphide of zinc, and alteratives, such as arsenic, are also recommended.

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#### THE HYPODERMIC USE OF ADRENALIN CHLORIDE IN THE TREATMENT OF ASTHMATIC ATTACKS.

In the *Medical News* of May 13, 1905, Kaplan after a trial of this plan of treatment says that if a conclusion is to be permitted from the number of patients studied in the Montefiore Hospital, it is safe to say that the contra-indications to the use of adrenalin chloride are generally overstated.

If carefully administered the drug may be used in effective dosage even in subjects with arteriosclerosis.

It is fair to contend that we have in adrenalin a drug which is more efficient in the relief of asthmatic attacks than those ordinarily used in the treatment of those conditions.

Even large doses of the drug freely used do not give rise to a glycosuria.

Adrenalin chloride has a distinct place in the therapeutics of asthmatic seizures.

Although relieving the paroxysms with greater promptness and certainty than most of the other drugs at our command, the hypodermic use of adrenalin chloride is in no sense curative of the disease as such, and equally useless as prophylactic injections. (Extracted.)

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#### RETENTION OF UREA IN NEPHRITIS COMPARED WITH THE RETENTION OF CHLORIDS.

According to F. Widal and A. Javal (*La Semaine Med.*, July 5, 1905), the classic picture of uremia is a mixture of symptoms due to the re-

tention of urea and of chlorids. Either of these substances may suffer retention separately, and give rise to distinct symptoms. The authors propose the terms "chloridemia" and "azotemia," to distinguish the two conditions. The condition of chloridemia can only be determined by a study of the balance between the chlorids ingested and those excreted. The chlorids do not accumulate in the blood, but pass to the tissues, where they attract water and give rise to edema. Urea, on the other hand, do not accumulate in the blood, and the presence of an excess in the serum is the best evidence of its retention. The normal quantity is 0.2 gm. to 0.5 gm. per liter; in the terminal periods of nephritis it may rise to 3 gm. or 4 gm. The excretion of urea must be gauged by the proportion between the ingested proteids and the urea in the blood. The retention of urea alone never leads to edema, the latter being caused only by a retention of chlorids. Urea, in fact, has been shown to have a certain degree of diuretic influence. Both chloridemia and azotemia have certain symptoms in common, such as Cheyne-Stokes' respiration and epileptiform attacks. Azotemia is especially characterized by anorexia and torpor, the former gradually becoming complete and the latter being a true narcosis. The proper treatment of chloridemia is a complete withdrawal of chlorids from the food, while azotemia must be met by a reduction in proteids. A diet of milk sugar is especially recommended for the latter condition, the amount being 100 gm. to 150 gm. daily. The authors decry the milk diet usually advocated in severe nephritis and uremia. They claim that it affords an excess both of water and of proteids. They advocate rather a mixture of milk and vegetables, especially the green and starchy vegetables. They do not prohibit meat altogether, but proportion its quantity to the amount of urea in the blood. These recommendations do not rest solely on a theoretic basis, but have been justified by practical demonstrations.—*Amer. Med.*

## OBSTETRICS AND PEDIATRICS.

### A NEW METHOD OF DELIVERING THE SHOULDERS.

LANE MULLALLY, M. D.

Kerr (*Medical News*, Sept., '05) describes a new method of delivery of the shoulder.

The patient lies on her left side, the head is delivered and rotation accomplished, he then places his left hand on the right side of the child's head and presses back firmly. This stretches the perineum from its circumference laterally and posteriorly toward the center and anteriorly.

By carrying the left shoulder back into the perineum the right shoulder is lowered into the pubic arch; when a pain occurs the left shoulder can not descend, because it is held well back and high up in the perineum.

The right shoulder descends, and as it does so it describes part of a circle around the left shoulder held as a fixed point high up in the perineum so that the course of the right shoulder is downward and slightly backward, bringing the prominence of the shoulder well back into the vulvo-vaginal outlet, and the right arm below the shoulder into the pubic arch.

One pain is usually enough to bring down the right shoulder and cause it to bulge well out of the vulva. When this is accomplished, the fingers of the left hand, which are making backward pressure, low down on the back of the neck or upper end of the spine, are closed and the physician presses up. This increases the space between the back of the child, and the maternal soft parts on the left side below and opens the right axilla. Through this opening in the axilla the forefinger of the right hand is passed, and hooked around the arm, close to the shoulder, bringing it down behind the child's back out of the vulva, and sweeping it over the pubic arch.

Then, before relaxing the grip with the left hand the right hand is placed on the left side of the child's head, and with the left supporting the perineum, by a downward, forward and slightly upward movement, delivery is effected.

Thus before there is the slightest strain on the anterior part of the perineum, the long diameter, from the tip of one shoulder to the tip of the other (bisacromial) is exchanged for the shorter diameter, from the axilla to the tip of the opposite shoulder (axilla acromial) as a presenting part, the difference again between laceration and practically no danger of laceration.

This procedure is mainly applicable to uncomplicated cases, which are in the great majority. It can be employed in most forceps' cases by removing the instruments.

### POST-PARTUM HEMORRHAGE.

Johnson (*Am. Journal Obstetrics*) recognizes the value of hot water uterine douches, and gauze packing to control dangerous post-partum hemorrhage, but would add the Faradic current. It possesses the advantage of being extra-uterine, and free from septic dangers. Johnson says that while other methods are worthy of trial, and have frequently succeeded in mild cases they should not be depended on or valuable time is lost. If serious danger threatens, the three approved remedies above mentioned should be resorted to at once in the order named—Faradic current, hot intra-uterine douches, and gauze packing. He cites cases in proof of his belief.

### VULVA-VAGINITIS AMONG CHILDREN.

Cotton (*Archio. Ped*) urges the establishment of detention wards in every hospital for children, in which the patients may be watched for at least 14 days before admission to the general wards in order to determine freedom from acute infections, and isolation wards for removal of suspicious cases. Female infants are especially susceptible to gonorrhoea. Children with this disease should be isolated in the care of a special nurse, and with individual toilet articles, bedding, etc.

The physician and nurse should exercise as great care in sterilization before going from them to other patients as with other acute infectious diseases.



## GYNECOLOGY.

C. M. REES, M. D.

## MALIGNANCY IN UTERINE MYOMATA.

In the October number of the *American Journal of Obstetrics and Diseases of Women and Children*, Dr. Henry F. Lewis, of Chicago, writes:

Uterine myomata, more properly called fibromyomata, are typically benign and innocent of growths which only cause trouble by reason of their mechanical presence, resulting in pressure symptoms; by reason of their influence upon the uterine musculature and endometrium, resulting in hemorrhage and by reason of their degeneration resulting in gangrene, infection or malignancy. Sarcomatous disease usually develop in the substance of one of several myomata, and may exist in the subserous interstitial or submucous varieties indefinitely. Carcinoma, contrary to the opinion expressed by many authors, is a more frequent accompaniment of fibromyoma of the uterus than is sarcoma. A few authors believe that the muscle cells of a myoma themselves may change and become of the epithelial character of carcinoma, just as they may become changed into the spindle cells of sarcoma. Roger Williams states that carcinoma co-exists with fibroids in 9 per cent. of the cases of fibroids, but that carcinomatous degeneration of the fibromyoma is of rare occurrence.

That there is an etiological relation between adenocarcinoma of the corpus uteri and fibromyoma seems probable, although the exact relationship cannot be stated. Richelot says that every fibroma of the uterus is accompanied by hypertrophy of the mucus membrane of the uterus. He also expresses the opinion that fibroids really predispose a uterus to malignancy.

## ASEPTIC OPERATIONS.

In the transactions of the Southern Surgical and Gynecological Association (1904) Dr. Henry T. Byford, of Chicago, gives a practical and interesting paper on "Some Points in the Technique of Aseptic Operating." He observes that as infection not infrequently occurs as the result of an imperfection in our antiseptic detail, it is well for us to occasionally discuss the subject and criticise our methods, that we may reject the bad and adopt the good. The most important point in the prevention of operative infection is, of course, to keep our hands out of septic matter for a considerable period of time before operating, for it is a physical impossibility to remove all infective material from the deeper layers of

the cuticle. He draws this comparison: If by looking through a strong lens we magnify the skin of the hands to the extent that the epithelial scales assume the size of the ordinary fish scales, and magnify also the bristles of the nail-brush in proportion it will not seem unreasonable to compare the scrubbing of our hands and fingers to the scrubbing of ten fishes with a brush whose bristles are much larger in diameter than the fish scales, or about as large as a thumb. On the human skin the scales grow in more layers than on fish, and are situated on rugae and papillae and in folds and sulci. Besides, the human skin has many hairs with scaly surfaces and individual follicles, and has also many sweat glands. When we reflect that these hair follicles and epithelial tissue are the natural habitat of the staphylococcus albus, we realize that the cleaning and sterilization of many fish skins is child's play compared with sterilization of our hands. In fact, our hands cannot be made clean and sterile except by removing the cuticle, "a procedure which I am not prepared to advocate." Gloves do not constitute an ideal coating. They interfere with delicacy of manipulation. They are dangerous because they excite sensible perspiration and thus bring germs from the deeper layers of the cuticle to the surface ready to infect the patient through possible tears and punctures. The old way of thoroughly preparing the skin and then applying a germicide that will harden the surface and check perspiration, and that can be removed from time to time during a long operation, still seems to be very nearly the ideal method of treating a surface that cannot be sterilized except in a most superficial manner. He considers of great importance in addition to scrubbing a certain amount of soaking which is necessary to soften and loosen up the dirt between the epithelial scales and at the bottom of depressions.

He thinks 20 minutes not too long to devote to scrubbing and soaking the hands in soapy water. Water drawn into a basin and frequently changed is preferable to running water, because a better and soapier soaking is possible. After a most thorough cleansing with green soap some stain or hardened inorganic matter that may be insoluble in the alkali is apt to remain on the skin, and hence a short scrubbing in diluted acetic, citric, or oxalic acid is desirable. This dissolves the remaining inorganic matter and more thoroughly exposes the underlying cuticle. In order to penetrate still deeper and to harden the cuticle which has been swelled and loosened by the alkaline scrubbing and soaking, a scrubbing and soaking in 90 per cent. or 95 per cent. alcohol is desirable, if not essential. The harder the cuticle becomes under this process the more completely are the underlying and unreachable staphylococci covered up and imprisoned in the depths of the cuticle. The hands would now be sufficiently prepared for a short operation, but they may be more efficient and more durably rendered safe for a long operation by an additional scrubbing and soaking for five minutes in a 1:2000 aqueous solution of mercuric chloride. This not only quickly destroys germs if it finds any, but it still further hardens the cuticle and forms a sort of film of albumen or albuminate

of mercury, which imprisons the germs beneath the surface. The film would be softened and perhaps be worked off during a protracted operation. were it not that by dipping the hands and arms in the mercuric solution to fortify or renew it every ten or fifteen minutes, and practically ensure an aseptic handling of the tissues during the entire operation. Dr. Byford deprecates the mixing up the steps of the preparation of the hands and arms by using a combination of green soap and alcohol, or by dissolving the mercuric chloride in alcohol. One substance interferes with the best action of the other, and alcoholic solutions of mercuric chloride have been found to be less efficiently antiseptic than aqueous solutions of the same strength.

This paper was freely discussed by Drs. Bovie, of Washington, D. C., Bonifield of Cincinnati, Stone of Washington, D. C., Charles H. Mays of Rochester, Minn., Martin of New Orleans, Williams of Baltimore, McMurtry, of Louisville, Ky., Sherrill of Louisville, Ky., Long of Greensboro. N. C., and Carr of Washington, D. C. In the main, those who discussed this paper were in accord with the plan of preparation as laid down and outlined by Dr. Byford, with one exception—i. e., in the use of rubber gloves, the general concensus of opinion being that rubber gloves, even after the most careful antiseptic preparations, afford a most valuable and safe protection for the hands.

## PATHOLOGY AND BACTERIOLOGY.

G. MC F. MOOD, M. D.

### THE PATHOGENIC ACTION OF AMOEBA COLI.

M. Ch. Dopter (Annales de L'institute Pasteur, July, 1905), in studying the pathogenic action of the Amoeba Dysenterica, concludes as follows: "That the Amoeba enters the intestinal walls through the mucous membrane and not through the sub-mucosa as usually claimed. It does not enter through the gland orifices, but through the epithelium which lines the internal surface of the mucous membrane, and proceeds thence into the adjoining inter-glandular tissue. At its point of entrance the amoeba invades the gland while going through the basement membrane of the epithelium. Advancing thus, it traverses the mucous membrane, where it is arrested for a time, having to pass through the musculosis mucosae, and emerge in the sub-mucosa. After it has entered the tissues, the amoeba excites at once, both locally and for some distance around an inflammatory reaction, which opposes its invasion. This reaction is soon followed at each point with which the parasite comes in contact by a process of necrosis, a constant manifestation, and one necessary to its pathogenic action.

### ACTION OF COPPER ON TYPHOID BACILLI.

A. H. Stewart discusses this subject in the *American Journal of the Medical Sciences*, May, 1905. When water containing typhoid bacilli is allowed to stand for a time, though there may be a temporary increase, their natural tendency is to die, and this they do gradually, with their entire disappearance in the course of a few hours or days. Tests were made, as to the time necessary for the disappearance of typhoid organisms placed in sterile Schuylkill water and that (unsterilized) taken directly from the tap and from the surface of the river, containing large numbers of water flora. A specimen of each of these waters, placed in vessels of glass, porcelain, tin and copper, were kept at room temperature, and plated every 15 minutes for periods ranging from 3 to 6 hours.

Sterile water inoculated with typhoid bacilli and placed in the copper vessels always showed the disappearance of the organisms in one (1) hour. Sterile water, similarly inoculated, and placed in tin vessels, always showed living organisms after 24 hours. The results with sterile water, similarly inoculated, and placed in glass vessels exposed to light, were not constant, but organisms were always present, at the end of 3 hours.

Sterile water, similarly inoculated and placed in enamel vessels, showed a slight decrease in the number of organisms in 3 hours. Sterile water, similarly treated and placed in aluminium vessels, showed that the typhoid bacilli had entirely disappeared at the end of 3 hours.

Raw tap water, inoculated with typhoid bacilli, and placed in glass vessels, showed occasionally a diminution in the number of typhoid organisms, but as a rule the number was increased at the expiration of 3 hours.

Raw tap water, containing considerable vegetable matter and large numbers of water organisms, when inoculated with typhoid bacilli in very large numbers and placed in a copper vessel, showed no living typhoid bacilli in from 1¾ to 2½ hours.

The amount of colloidal copper given off from a 1 liter copper vessel in 3 hours was 1 part to 4,000,000. This amount killed all of the added typhoid organisms in from 1¾ to 2½ hours, and chemical experience has shown that this amount of colloidal copper is harmless, when taken into the human system.

In epidemics of typhoid fever, water could be purified of typhoid organisms by allowing it to stand in a copper vessel for 3 hours.

### AGGLUTINATION OF DEAD CULTURES.

E. Andrade (*Medical News*, May, 1905) concludes that living and dead cultures of typhoid bacilli are about equally sensitive to the action of the agglutinins of typhoid fever, though they may take longer to effect the dead than the living. Occasionally it is quicker with the dead cultures. The dried blood method is equally effective in both. The reaction is more characteristic with the dead than with the living cultures; moreover, there are no pseudo-reactions with dead cultures. Dead cultures retain their sensibility to the agglutinins for quite a long time, the writer having used one culture for 6 months, which still acts typically.



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COMMUNICATION FROM THE SECRETARY.

(COUNTY SOCIETIES WITH MEMBERS.)

The Secretary herewith publishes for the second time the list of Societies which have affiliated with the State Association according to the Constitution and By-Laws recently adopted by the Association, and realizes the incompleteness of the same. He appeals to the secretaries of the County Societies to aid him in making this list as complete and correct as possible. This can only be accomplished with their aid, and he earnestly requests the County Secretaries to carefully compare the published lists with their own, and to notify him as soon as possible of any alterations or corrections, so that the next list, which will appear in the November issue, and which will be the final publication, shall be complete in every detail. Counties which have not yet affiliated are urged to do so before the last publication. Affiliation consists in applying for a charter, sending a list of officers and members, and in sending the three dollar per capita dues. Until all of these requirements are fulfilled, no charter can be issued or members of County Societies accepted as members of the State Association.

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### South Carolina Medical Association.


Next Annual Meeting at Columbia, S. C.,  
April 18th, 1906.

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# THE JOURNAL

OF THE

## SOUTH CAROLINA MEDICAL ASSOCIATION.

4 Vanderhorst Street, Charleston. S. C.

ROBERT WILSON, Jr.,

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THE JOURNAL is published monthly under the auspices of the South Carolina Medical Association. Members who do not receive their copies will please notify the Managing Editor at once. Secretaries of county societies are requested to send reports of their meetings, and items of news that may be of interest to the profession. Original articles are solicited. Articles should be type-written; and illustrations sent with articles will be printed at the expense of the writer. Reprints will be furnished at the rate of 75c. a page for a hundred copies.

All matter must be in the hands of the editor by the 10th of each month.

### EDITORIAL COMMENT.

#### SCOPOLAMINE.

In a paper recently read before the Medical Society of the State of Pennsylvania, Dr. John V. Shoemaker discusses scopolamine and calls attention to the danger attending its use in large doses. This drug is said to be identical with hyoscine, and the commercial article contains an admixture of "atropine" which is isomeric with hyoscine or scopolamine. This latter fact may explain variations in the action of the commercial scopolamine hydrobromide, depending upon the quantity of atropine present. As a mydriatic scopolamine resembles atropine, but upon the circulatory and nervous systems its effects are quite different. "Scopolamine does not affect the respiration, except in large doses, which produce the Cheyne-Stokes type. Small doses slightly increase the blood pressure, but large doses decrease it. The heart's

action is made slower, owing to a sedative action upon the cardio-motor apparatus. Cerebral activity is diminished and the electrical excitability of the brain is reduced. Narcosis and coma are produced by full doses. Motor reflex paralysis indicates a marked depression of the spinal cord, and there is consequent profound relaxation of the voluntary muscular system." Two drops of a 1% sol. instilled for mydriasis in to the eyes of an adult produced complete muscular relaxation and loss of consciousness which lasted for four hours. This was followed by delirium lasting two hours, and then sleep for an hour and a half. There were no subsequent ill effects. It is contraindicated in the young and the old,—in nephritis, scarlatina and diphtheria, and heart disease. The antidotes are "the diffusible stimulants, as nitroglycerine, strychnine and caffeine, artificial respiration, the administration of oxygen by inhalation, hot external applications, friction of the skin, and electricity." Morphine is synergistic. Karff recommends giving scopolamine gr 1-640 and morphine gr. 2/5 in three doses, the first to be given 2½ hours, the second 1½ hours, and the third ½ hour before the operation. When used preliminary to chloroform or ether it reduces the excitement accompanying the administration of these drugs, and lessens the tendency to vomit. Dr. Shoemaker justly remarks that there is no such thing as a perfectly safe anaesthetic, and warns against the large doses used in this country, where surgeons give scopolamine gr. 1/64 with morphine gr. 1/6 at intervals of an hour. In view of the uncertain composition of the commercial drug, and personal idiosyncrasy, such doses may be very dangerous.

#### THE DISPENSARY AND PATENT MEDICINES.

The work of the State Dispensary in exposing the composition and limiting the sales of certain patent medicines which contain a very large percentage of alcohol should receive the hearty support of the whole medical profession. We have never been in favor of the Dispensary,



but candor forces us to give the devil his due and to acknowledge a feeling of gratitude for the crusade against this class of fraudulent and dangerous preparations. The recent order has not met with the universal approbation of the lay press, but the fraud perpetrated by such widely advertised and generally used "medicines" as those in question is not generally appreciated, nor is the danger of using alcohol in disguise well understood. That the prolonged use of such nostrums may produce a state of chronic alcoholism in the most innocent and unsuspecting is not imagination, it is fact. Samuel Hopkins Adams, writing in *Colliers Weekly*, Oct. 28th, says that Peruna, which may be taken as a type of its class, contains less than one-half of one per cent. of drugs, and these of slight potency, the rest is alcohol and water. The cost of manufacturing this elixir of life is about eight and a half cents a bottle, including bottling and labelling; the rest of the dollar paid by the consumer is profit. Hostetter's Bitters, Lydia Pinkham's Compound, Hood's Sarsaparilla and Ayer's Sarsaparilla are other well known compounds which fall into the same category, containing from 18% to 40% of alcohol. The order forbidding the sale of these nostrums save on a physician's prescription places the power of control, in a measure at least in their hands, and we feel confident that not many will be found to betray the honor of their calling. But how about the druggists? How many of them will have the moral courage shown by a country merchant of our acquaintance, who discontinued the sale of Peruna because he discovered by accident that it was an intoxicating beverage? Have pharmacists a lower standard of honor than physicians? It remains to be seen.

At the last annual meeting of the State Association resolutions were passed by the House of Delegates providing for the appointment of committees on tuberculosis and pharmacy. If these committees have been appointed, we have not heard of it. Time is passing.

"Medicine is the noblest of professions; the meanest of trades. Unless you can live lives of purity, of virtue, of honor, and of honesty, seek a livelihood elsewhere, and insult not the gods by striving through base methods and ignoble ambitions to resemble them."—*Gaillard Thomas*.

#### ORIGINAL ARTICLES.

##### SURGERY OF THE KIDNEY.

CHAS. M. REES, M. D., CHARLESTON, S. C.

It is probably true that as early as 1670 Zambecarius, and two years later Roonhuysen had proved by experiments on animals under the best circumstances that one kidney could perform the function of elimination after its fellow had been removed. Before Feb., 1880, (the date of the first nephro-liphotomy), besides G. Simon's incomplete work, not more than a score of articles on renal surgery had been written,—these chiefly on nephrectomy. In 1879 Tait removed a pyosalpinx for the first time, as well as doing his first cholecystotomy. His first operation for primary ruptured tubal pregnancy was done at about the same time. At this time Kimball, Dunlop, Peaslee, Thomas, Thornton and Spencer Wells were doing a large amount of work in operating for such large ovarian cysts as are rarely seen at present. In the course of fifteen years thousands of abdominal sections had been made.

It was probably the work of these abdominal surgeons that led up to the development and progress of the surgery of the kidneys and ureters. A most complete and interesting account of the history and progress of the surgery of the kidneys and the ureters is given by Dr. J. Wesley Bovée in his address as President of the Southern Surgical and Gynecological Association, 1903. With the advent of antiseptics and asepsis in 1880, and from that time forward the surgery of the kidneys and ureters has rapidly developed. Investigators become chiefly engaged in the study of surgical technique, with the idea of the prevention of septic invasion. Czerny, by doing a re-section of the kidney for an angio-sarcoma fol-

lowing an injury, in 1887, materially advanced the conservative surgery of these structures. In 1881 Hahn was doing nephrorrhaphy for movable kidney, an operation which now has been done thousands of times. In 1888 Bozeman, of New York, succeeded in catheterizing a ureter through a vesico-vaginal fistula, and flushing out a pyonephrotic kidney. Grunfeld's speculum and mode of catheterization, it has been suggested, was the origin of Dr. Kelly's method and instruments, and Pawlick has made objections to Kelly's claim of originality. Dr. Bovee of Washington, has made valuable contributions to the surgery of the Kidneys, and to conservative surgery of the ureters. Dr. Dougal Bissell, of New York, has devised and successfully performed a most ingenious operation for transplanting the ureters in the bladder wall. However, as the scope of this paper does not admit of a discussion of the surgery of the ureters, and was designed to deal with the conservative surgery of the kidney, I trust you will pardon my wandering.

In 1880, Henry Morris planned and successfully performed nephrotomy for renal calculus, since which time the operation has been found to have a wide field of usefulness, in other lesions of the kidney. But until the last quarter of a century nephrotomy was performed only for the evacuation of pus. At the present time nephrotomy is performed in several different classes of cases. As an exploratory operation when the kidney is neither suppurating nor sacculated, nor distended; when the kidney is in a state of sacculatation or suppuration or both; when there is distension or pyelitis; in cases of enlargement of the kidney, in some other way than by nephrectasis; to give exit to urine and allow of search for a calculus in obstructive anuria. The simple division of the capsule, with or without the removal of a portion of the cortex of the kidney, for the relief of great renal pain due to mechanical congestion inflammatory hyperaemia, or subscapula extravasation of blood. Nephrotomy is a safe operation with a mortality

much lower than nephrectomy. When a kidney has been destroyed beyond functional activity nephrectomy is the only operation, except in those cases where the kidney is sacculated and distended with pus, having extensive and strong adhesions, the separation of which would necessitate an opening into the general peritoneal cavity. Here the preferable operation is a lumbar incision and evacuation of the pus, followed by the suturing of the shell of the kidney to the margins of the lumbar incisions, and drainage of the cavity. In properly selected cases following nephrectomy the functional activity of the remaining kidney will be markedly increased, assuming the double duty which it is called upon to perform with satisfaction and comfort. Examples of this I have had under observation for several years. It is not, however, true, that when a kidney, with a portion remaining which is still partially performing its excretory functions, or in one which is temporarily impaired by an acute inflammation or an obstruction of a stone in its substance, in the pelvis of the kidney or its ureter. If such a kidney is removed the remaining kidney will usually not assume the work of the two, as in cases where its fellow has been entirely destroyed and its remains removed. But it will soon become insufficient, diseased, and will perish. Again, it is not possible to determine to what extent the kidney which is to remain is already diseased. A kidney and a half, or a quarter, is better than one kidney. Except in very fleshy subjects the kidney is easily reached through a lumbar incision, and with care and safety its entire surface can be examined. In cases with perinephritic inflammation and a fibrous capsule thickened and densely adherent, the capsule should be divided from one end of the kidney to the other to relieve the tension and the capsule peeled away from the parenchyma of the kidney, and all the thickened portion cut away. Free incisions into the kidney substance for an examination of its interior down to the pelvis can be made almost with equal safety. Search for a stone in the kidney



or its pelvis can be thoroughly made. From such an incision cavities in the kidney can be safely drained, diseased portions and cicatrices removed. Conservative surgery has here one of its widest fields of usefulness. Hemorrhage from an incision into the kidney may at first be alarming, but it will soon stop, or can be easily controlled either by packing and drainage or sutures, and healing is rapid. Nephrotomy is not attended generally by shock, and the results are almost universally gratifying. Due to the uncertainty of the diagnosis if stone in the kidney, nephrotomy has not impressed surgeons with the same confidence in the operation which belongs to operations upon the gall-bladder. The X-ray has proved a valuable aid to the diagnosis of stone in the kidney, however repeated failures to discover the stone by X-ray examination does not in all cases contra-indicate an exploratory nephrotomy. An operation upon the kidney, in which it is expected to find a stone should not be considered a failure, when the symptoms cover those which belong to a stone, if a stone is not found. If the changes in the kidney are sufficient to give symptoms simulating those of the stone, capsule splitting and a section of the kidney will doubtless relieve many cases, the symptoms of which closely resemble those of a stone, but because of the uncertainty of a diagnosis are not subjected to an exploratory operation. Pain of stone may be simulated by any gross pathologic lesion of the kidney or ureter, such as tuberculosis, a tumor, hydro nephrosis, etc., while ordinarily renal colic is associated with intra renal retention from obstructed outflow. In certain chronic affections of the kidney with acute exacerbations the distention of a resisting capsule from within may be and often does give rise to a typical renal colic.

I will not here give in detail the symptoms which are present in stone in the kidney, nor of other lesions of the kidney with symptoms which simulate those of stone. Reference can be made to the volumes on Surgical Diseases of the kid-

neys and Ureters by Henry Morris, where a most complete account is given.

Reference to the clinical record of a case with stone in the pelvis of the kidney causing obstructive anuria and great renal distension, which came under my care for treatment will serve to illustrate.

A white woman, visiting our city from Washington, D. C., was seized with a severe attack of lumbago, which was a recurrence of several previous and similar attacks. The patient showed evidence of intense suffering, with the surface of the body moist and cold. Temperature elevated to 102 degs., with a weak and rapid pulse. Pain was referred to the back and right loin, passing forward into the groin. Palpation of the right side was impossible on account of extreme tenderness. This condition continued more or less for three days, when her symptoms subsided. A specimen of urine was obtained, and examination of this found it to be acid, with a trace of albumen, and rather high specific gravity. Microscopical examination found some kidney epithelium, a few blood corpuscles, pus cells in abundance. After the pain subsided a large and tender kidney could be palpated. I gave an opinion of stone in the kidney and advised operation. This was refused, but only two more attacks similar to the one in which I first saw her were required to gain her consent to operation.

Operation was made by the lumbar incision, the fatty capsule was firm and indurated with strong adhesion to the surface of the kidney. These caused some difficulty and delay in separation. The kidney was approximately twice as large as normal. The surfaces were smooth, except along the convex border, which was irregular with nodular masses of cicatrix. The whole kidney was extremely tense. A tumor consisting of the upper dilated portion of the ureter and pelvis of the kidney, in size about that of a hen's egg, was found filled with fluid. Protecting the surroundings with gauze, this tumor was aspirated, and the fluid, which was urine, was drawn off. A free incision was then made into the dilated

ureter, and an irregular stone about the size of the end of the thumb was removed. A quantity of semi-solid material, which had not consolidated into a stone was also removed. A sound was then passed from the kidney end through the ureter down to the bladder to determine any further obstruction which might exist. None was found. This cavity was then thoroughly irrigated, and the ureter washed out from the upper end down to the bladder. The incision in the ureter was then closed with cat-gut suture. Returning to the kidney, the fibrous capsule was incised and slit from one end of the kidney to the other, along the convex border. The fibrous capsule was enormously thickened, and firmly adherent to the surface of the kidney. It was with some difficulty peeled away from the kidney, leaving the kidney bare of capsule for about three-fourths of its surface on either side of the convex border, and from end to end. All the reflected portion of the capsule was then trimmed away with scissors. A free incision was made into the kidney to one side of the convex border, and deep into its substance, through what appeared to be healthy tissue. The interior of the kidney was thoroughly explored with the finger. A similar incision was made on the opposite side, extending from one end to the other, thus removing a large wedge of kidney substance, which appeared to include all the diseased portion. Bleeding was rather free, but was readily controlled by sutures, which approximated the cut surfaces of the kidney. A gauze packing and drain were placed on the surface of the kidney, and brought out at the lower end of the wound. The incision through the muscles was closed throughout over the kidney. The urine was bloody for a few days, but rapidly increased in quantity. The case made a rapid and very satisfactory recovery.

#### A PLEA FOR A SIMPLER MATERIA MEDICA AND MORE RATIONAL MEDICATION.\*

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In selecting this subject for my paper I feel that I have taken a position which places me on the defensive, in that what I will advocate are in my opinion advances in the line of Materia Medica and Therapeutics. Practically all advances of every kind as a rule are recognized by the few who are termed cranks by those who do not recognize the virtue of the thing advocated, whatever it may be. Knowing that such is the case, and that it is but human for us to consider the "other man" cranky, if he brings forward anything radically different to what we think, I, feeling absolutely certain that my position in this matter is the correct one, am perfectly willing that you think anything that you care to in regard to me and what I will advocate, for, in time, these things are as certain to prevail as day is to follow night. I believe that our Materia Medica is needlessly bulky, that not only is it needlessly bulky, but that in many cases it is absolutely harmful to the medical student and the young practitioner. To come to my subject proper, I make the claim that it is our duty as physicians to use the active principles of the various drugs where they fully represent its action instead of any fluid preparation or any powdered drug. I make this statement because of the fact that where the active principle fully represents the drug, it necessitates the learning of one dose only, instead of half a dozen or more as we have to do with many of the common drugs. Any one who looks back over his entrance into the profession can readily see what a help it would have

\*Read before the Mecklenburg Co. Medical Society



been to him if such a state of affairs had existed at that time. Not only does the use of the active principles make *Materia Medica* easier to the beginner by simplifying this branch, but it also gives us reliable medicants which we can never have in any other way. Hare states, "Not long since an intimate friend of the writer bought from five of the leading druggists in Philadelphia six ounces of tincture of *nux vomica*, which were stated to have been made according to the directions of the United States Pharmacopoeia. That made by perhaps the leading druggist of the five contained twice as much strychnine and brucine as it should, and had twice as much solid residue; or, in other words, a physician prescribing this tincture in full dose would probably have poisoned his patient and reported the case as one of unusual susceptibility to drugs! On the other hand, the author has recently seen a tincture of *nux vomica* which contained only a trace of alkaloid, but had much inert solid residue. In neither instance was the druggist dishonest intentionally, but one had used the crude drug which was unusually rich in alkaloids, while the other had purchased *nux vomica* beans which, by reason of their immaturity, bad surroundings, or exposure to weather, were very poor in active principles." He also says, when it is impossible to secure assayed products, "The physician should employ the alkaloid in pill form, or, if solutions are desirable, the alkaloids may be added to alcohol or water and given by drops, as is the case with any ordinary tincture. \* \* \* \*"

All drugs should be physiologically tested when their chemical assay is impossible. Not long since several thousand pounds of ergot were found to be worthless on being tested physiologically by one firm; but it was put on the market nevertheless, for certain manufacturers do not employ this method of examination. Constant uncertainty is a dangerous element when dealing with patients who are desperately ill; and in many cases failure and discouragement may both be avoided if the physician will see to it that the drugs which he administers are capable of doing

what he requires of them. A poor drug to the physician is worse than a rusty knife to the surgeon; for the injury in the one case is unknown, while in the other it can be carefully watched and guarded." If alkaloids are so reliable as to be used in case of last resort to secure certainty and results, why not use them all the time in preference to liquid preparations which have to be constantly watched to secure reliability? For unless the physician specifies in every prescription or sees that every prescription he writes is filled at the drug store of his choice where he has an understanding with the pharmacist as to the quality of drugs entering into his prescriptions he cannot be sure of the reliability of the drugs he is using. But why go to this unnecessary trouble or take this unnecessary risk? What a deplorable affair it would be for a physician to use a preparation of *nux vomica* of little strength, and, finding that to secure the results demanded, a dose of 30 to 40 m. would have to be given, and then to be so unfortunate as to secure a preparation of double the officinal strength when his prescription is filled the second time, and to have this last poison the patient as it surely would. If, in a case like this, the active principle entirely represented the drug, then, in my opinion, the physician is culpable, but if it does not, and the physician is careful to secure his medicines from what he considers a reliable source, he is not to blame, but public opinion would damn him just the same. Further comment is unnecessary, but I will add that I trust that such accidents with tincture of *nux vomica* will never befall any member of this Society, nor that he will ever use any of the fluid extract of ergot made from the crude drug mentioned above.

I claim that the active principles should be used instead of the galenicals, because, in making the galenicals, many pharmacists buy their drugs already powdered, and has, therefore, no guarantee that he has an unadulterated article. If he does not buy it powdered, he is not prepared to properly powder it. Sophistication is so easy in powdered drugs, and

in this commercial age, so likely to occur. I think that tinctures made from the crude drug, by the retail pharmacists should not be allowed, but, if they must be used, they should be made by diluting the most reliable fluid extract that can be procured when it is possible to make them in this manner. Can any one say anything in the defense of the tincture, except that its use is customary?

Another reason why we should use the active principles is, because the strength of the galenicals may be changed from time to time, necessitating another study in dosage also making it possible for undesirable results to occur. Take as an example, the last Pharmacopoeia which went into effect September 1, 1905, changes the strength of tincture aconite from 35% to 10%, and the corresponding change in dose. This change in strength makes it possible to have a patient get too much or too little of this important drug, and in either case it may cost the patient his life. Tincture strophanthus was also changed from 5% to 10% and the patient may be poisoned by the physician not knowing of this change in strength, or the pharmacist may use the old strength and the patient suffer from the lack of this drug.

Why do the text books give the dose of fluid extract gelsemine from 2 to 30 m., and why do some state that the preparations should be made from the green drug, while others state that the preparations should be made from the dried drug? The reason for the difference seems plain to me. It can possibly be nothing other than that one preparation has the proper amount of gelsemine in it while the other has not; and some think the green drug contains the most alkaloid, while others think there is more in the dried drug.

Has any member of this Society a guarantee that he will get a reliable preparation of this drug the next time he wishes to use it? Does it not then seem a common sense thing to do to use the active principle instead of the unreliable galenical preparations?

I contend that any physician who gives internally a fluid preparation of pilocarpus does his patient a wrong, for how does any one know whether there will be more pilocarpine present than jaborine, and if jaborine is in excess the effect will be opposite to the one expected—like that of atropine. Have we, as physicians, any right to run such a risk, when we know that pilocarpine represents fully the usual action of this drug—the diaphoretic action we expect when we use pilocarpus?

It is a well known fact that the various preparations of colchicum are uncertain at best, that some are not as good as others. Why not leave out of the *Materia Medica* the inferior ones? Would not this be the logical thing to do? But why use any of them when colchicine fully represents the drug, and is absolutely certain in its effect?

I believe that we should omit from our *Materia Medica* entirely all mention of belladonna, (and all other drugs where the active principle fully represents them). I make this statement because atropine fully represents belladonna, and to have the various preparations of the drug in addition to atropine, serves only to confuse. Does any physician doubt that atropine fully represents belladonna? If not, then, do you not think that it would be much easier for the student to remember the dose of atropine than the number of preparations of belladonna we now have in addition to the dose of atropine, which, of course, he must know? If you admit these things, then would not this be an advance?

Why is nux vomica used when strychnia fully represents this drug? Is there any physician present who would depend on tincture nux vomica as a heart stimulant? No, you want just a certain amount of strychnia, and you do not know how much you will get, if you use the tincture. Yet you use other galenicals when you could use their active principles.

There are many other reasons why the active principles should be used: It would prevent substitution, for no phar-



macist knowing the strength and activity, therefore the danger, would substitute. Another reason to prevent substitution would be the fact that the physiological action and therapeutical uses are so certain in action and so well known, that substitution would be inevitably exposed.

If physicians will use the active principles, it will make them better doctors. Because of their powerful action no one can use them without knowing their physiological action perfectly, when this is known and the condition of the patient recognized, and the remedies applied in moderate doses, repeated, if necessary, until the desired effect is produced, the probabilities of benefit to the patient are much greater than when the old way is followed of giving a galenical preparation of unknown strength in the dose advised by the text books. When the latter course is taken if the effect is not produced, the doctor calmly folds his hands and either trusts to God or says, "Nothing can be done." When physicians know thoroughly the physiological action, use the active principles, and know the indications for a remedy, then we will have great progress in medicine. We will then have fewer therapeutic nihilists, for therapeutic nihilism is caused by: Lack of knowledge of the physiological action of drugs; lack of knowledge of the condition of the patient; lack of knowledge of the indication for drugs; or unreliable drugs,—one or all. The use of the active principles removes the last and causes the physician to study the other three causes, and, in this manner, tends to remove them also.

I believe that the use of the active principles is one of the greatest advances in medicine in recent years, because it is teaching men to think of the physiological action of drugs, to study the condition of the patient, and apply the drug that is indicated in doses sufficient to produce the desired effect, instead of using complex prescriptions whose physiological action they can only guess. The knowledge and confidence gained by their use makes the physician dissatisfied with secret and proprietary preparations, and,

in this manner, is sounding the death knell of all such preparations, and is building up a class of thinking physicians who want to know the composition and action of the drugs they are asked to prescribe. If this knowledge is not forthcoming they refuse to use them.

In conclusion, I will say that I contend that any physician who uses galenicals when the active principle entirely represents the drug is as far behind the times as a physician who uses powdered cinchona bark or fluid extract of cinchona for the quinia that is in it, for he is doing this very same thing when he uses any galenical for the active principle that is contained in it. I firmly believe that any pharmacist, however competent and careful he may be, is more liable to have a difference in strength in any two samples of the same galenical preparation he may make than he is to have them the same strength as they should be.

I also claim that we should eliminate from the *Materia Medica* all galenicals, extracts, and powdered drugs, when such drug has an active principle which fully represents it. These views, I know, are radical, and, at the present time, not at all likely to be accepted and acted upon, but while this is true, it is nevertheless the common sense thing to do, and is an advance in *Materia Medica* and Therapeutics whether it is admitted or not.

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#### OPERATIVE TREATMENT of CONCOMITANT AMBLYOPIC SQUINT.

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Concomitant squint or cross eye is an easily recognized condition due to a faulty muscular co-ordination of the two eyes, the latter in turn being due as a rule to a reduction in the visual acuity of one or both eyes.

This diminution in vision may be due to errors of refraction, the correction of which restores more or less normal vision in the affected eye or eyes, or it may be caused by the well-known fundus changes of intraocular diseases as well as

by opacities of the various media which do not admit of much visual improvement from the correction of refractive errors. Finally there are many cases, in which there are no apparent ocular lesions to account for the marked visual reduction with disproportionately small refractive errors, the correction of which is usually correspondingly unsatisfactory. To these last the term amblyopic squint may well be applied.

The faulty coordination may be a primary condition in some instances and by causing a deviation of one eye it produces what is known as amblyopia ex anopsia. This class of cases in the opinion of many ophthalmologists is small as improvement in visual acuity does not commonly follow the correction of the squint when the amblyopia has been marked and when the corrective lenses do not make a noticeable improvement in vision at once.

The defective vision is generally primary and the deviation secondary.

In concomitant squint there is no asthenopia and no diplopia as a rule; the patient consults us solely on account of the noticeable disfigurement, and its cosmetic importance is therefore in many cases paramount.

The deviating eye is not used and there is in consequence a loss of binocular vision.

The aim of treatment should be to correct the deformity and to bring, if possible, a parallelism of the visual axes and a restoration of normal binocular vision.

There is still, in spite of the prominence of the deformity, considerable ignorance among members of the profession, as well as the laity, as to the meaning, cause and treatment of cross eye. There is an effort always to explain its occurrence, and convulsions, the exanthemata or some severe systemic diseases are frequently cited as exciting causes, whereas, we recognize these only as coincidences, the real cause as a rule antedating these conditions. In exceptional cases squint spontaneously disappears in eyes where the visual acuity is good and the muscle overcomes the insufficiency. When bilateral defects are present the

strabismus may be alternating, but most commonly we see permanent unilateral convergent or divergent squints as a result of hypermetropia, myopia, or astigmatism, associated or not with permanent intraocular changes.

In all varieties of concomitant squint the first duty is to carefully estimate the refractive error and correct it with appropriate lenses for constant use. Glasses, though in some cases they may be discarded later, are to be regarded as a necessary and indispensable evil in the treatment of squint, whether we operate or not. Mydriasis, the ophthalmoscope, retinoscopy and the ophthalmometer enable us even in children who have not learned to read to intelligently correct the ametropia. The trial lenses further assist us in older patients by allowing us with the aid of data obtained by the purely objective methods to prescribe the lenses for each patient, which seem most comfortable and give the best vision. This being satisfactorily completed our next step is to consider what measures will facilitate most rapidly and perfectly the restoration of axial parallelism and the binocular function, the latter being possible in only a minority of cases. We have at our disposal the non-operative or the operative plans of treatment.

The non-operative plan consists in the use of cycloplegics, orthoptic or gymnastic exercises with prisms, the stereoscope, and the exclusion pad. With the exception of the last these methods require an expenditure of time and patience on the part of both patient and oculist which frequently render their use discouraging and impracticable. The exclusion pad necessitates the use of the squinting eye, encourages visual acuity and improves the coordinating power of the faulty muscles and is the simplest and most readily comprehensible method of orthoptic exercise. It is in alternating squints, in periodic monocular squints and in all squints where the chief etiological factor appears to be an uncorrected ametropia that the results of the non-operative plan are most gratifying and satisfactory, and in which improvement in visual acuity (in



addition to the removal of the deformity) may be most confidently expected. Glasses and exercises are prescribed in such cases with a reasonable hope of success and operative measures should only be undertaken when a year or two has proved the futility of depending entirely upon them. In the class of cases whose etiology is an amblyopia with or without fundus changes, and with serious destruction of visual acuity, glasses and orthoptic exercises must be tried for a reasonable length of time, but failure must be predicted as almost certain, when such conditions obtain, and operative treatment is then demanded.

Tenotomy, advancement and resection combined or separately and muscle tucking are the means now employed. The differences of opinion and problems for discussion turn largely upon the age at which such measures should be undertaken and the selection of the best plan of strengthening the weak and weakening the strong muscle or of combining both suggestions.

Convergent squint being rationally associated with the exercise of the power of convergence is usually associated with hyperopia and appears at an early age. Divergent squint is most often caused by myopia, it develops later in life, and may not appear until after or about puberty.

Opinions differ as to the best age for operating on children with convergent monocular squint, some advising immediate operation at any age as soon as the failure of glasses and exercises to improve the vision and correct the deformity has been clearly demonstrated,—others advocating anywhere from seven to twelve as the proper time for interference.

To weaken the overacting muscle tenotomy is almost universally employed, though forcible stretching has been suggested.

To strengthen the weak muscle advancement is the favorite operation, there being many varieties of technique, the essential part of all, however, being to sever the muscle from its attachment and to secure it nearer to the corneoscleral junction by sutures passing through the mus-

cle and the episcleral tissue. The objection to all of these operations is that the suture on account of the strain upon it, whether a tenotomy of the antagonistic muscle has been done or not, has a tendency to give way by cutting through, an accident which is often post operative and then beyond control. Various special needles and stitches have been devised to obviate this with only partially satisfactory results because the immediate and desired effect of the advancement is sometimes modified and the final result altered.

A suture which will invariably maintain the immediate result obtained on the operating table has been devised by Dr. Robert G. Reese, of New York, and the desired strength for the weak muscle is obtained by a resection and shortening of it, rather than by an advancement.

My method of stitching the resected muscle described suggested itself to me after seeing his operation as even more simple, and it seems to be to me especially adapted to those cases of Squint depending upon amblyopia of high degree with fundus changes or medial opacities of such a nature that the restoration of axial parallelism is difficult and binocular vision impossible, because no improvement in vision is to be anticipated. I have performed it successfully in a number of cases and am convinced that it offers decided advantages in comparison with the various methods of advancement, I am familiar with.

Cocaine or general anesthesia can be used according to the temperament of the patient, the former being more preferable, of course, and adrenalin solutions make the operation more or less bloodless.

The instruments needed are muscle forceps, strabismus hook and scissors, fixation forceps, speculum, a needle holder and needles with strong sterile silk sutures. After properly cleansing the eye a vertical incision is made over the weaker muscle, its tendon exposed, and while the belly of the muscle is held with a pair of advancement forceps it is severed near its attachment and separated somewhat from the conjunctiva and sclera.

The needle is passed through the conjunctiva (at (A), see Fig.) then the tendon (B) and then the under side of the outer part of muscle and then conjunctiva (C) successively; the needle is then re-inserted (at D) and passes through conjunctiva, muscle, tendon and conjunctiva in the reverse order (E F G), leaving the ends (H H) ready to be tied. As much of the muscle as seems necessary, judging from the degree of squint, is cut off behind the grasp of the muscle forceps and the gap is filled by tying the suture ends securely at I.

The eyeball is thus drawn into its proper position and it is impossible for this suture to slip or give way subsequently.

For high degrees of squint tenotomy of the opposing rectus is also necessary and this is most easily accomplished after exposure of the weak muscle and clamping it with the forceps, by means of which we can rotate the ball outwards and get easier access to the tendon of the strong muscle.

The subject of ophthalmic myology is still in a formative stage, and the correction of squint demands much judgment and experience and even thus equipped there is an element of uncertainty as to the immediate as well as remote results of the operation.

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#### PUS-TUBES.\*

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A. E. BAKER, M. D., CHARLESTON, S. C.

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There is no disease in Gynecology which endangers a woman's life more than pyosalpinx. This being true, no subject more important could have been assigned for our discussion to-night, and I trust each one here will discuss it freely, and at the same time be thankful that he is not of that sex which renders him heir to the disease.

The dangers and complications of pyosalpinx are not unlike those of appendicitis. We have inflammation and

suppuration going on in the abdominal cavity, the most delicate and vulnerable portion of the human body. Any such invasion into the peritoneal cavity, causing acute and progressive peritonitis renders medicine of no avail except to palliate pain for the time being. Surgery then holds out the only hope in such grave conditions. No delay should be allowed, but most active steps should be taken to get rid of this suppurating organ.

*Etiology.*—The pus formation in the fallopian tubes is due to any of the pus-producing micro-organisms, which usually find their entrance through the vagina into the uterus, then to the tubes. Many writers lay great stress upon the frequency of this disease being due to the gonococcus. Drs. Sangers and Rasthorne found tubal disease in 33% of all women affected with gonorrhea.

However the pus of pyosalpinx varies greatly in character. In the early stages of the disease it is actively septic and contains a variety of micro-organisms.

These organisms are the gonococcus, streptococcus, staphylococcus, the bacillus coli-communis, the tubercle bacillus and the pneumococcus.

Before taking up the character of pus produced by these organisms, I want to call your attention to the anatomical condition of the fallopian tube when distended with pus or any other fluid. Its walls gradually become thinned, this thinning of the tube-wall predisposes to rupture or leakage, and the contents escape into the abdominal cavity. A pyosalpinx often becomes adherent to the rectum, to the small intestines, or to the bladder. These adhesions may break down and the wall of the intestine or the bladder becomes perforated and the pus is discharged in this way. In some unusual cases the obstruction in the lumen of the tube is temporarily overcome, and evacuation takes place through the uterus, followed by re-filling of the tube.

This, however, is a very unusual occurrence and is not as frequent as some writers believe it to be.

In the later stages of pus tubes the organisms become inert, die and disappear,

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\*Read before the Charleston Surgical Club, Oct., 1905.



so that in the majority of cases of chronic pyosalpinx the pus is found to be bacteriologically sterile. Observation on this subject made by a number of investigators show out of 133 cases of acute and chronic suppuration of the uterine appendages in which the pus was examined bacteriologically no organisms whatever in 82 cases—in other words, the pus was sterile in about 61% of the cases.

The pyosalpinx in time, therefore, becomes inert so far as any inflammatory action is concerned, and resembles a chronic abscess in any other part of the body. However, this chronic abscess may at any time become reinfected by septic organisms entering the abscess by way of the uterine cavity, or adherent loop of intestine or the bladder.

I quote from a writer who says if a woman survives the dangers to which she is exposed from a pyosalpinx, the pus tube may in time become converted into a hydrosalpinx, the solid constituents of the fluid becomes absorbed or deposited upon the cyst walls and a clear watery fluid remains. In hydrosalpinx the recesses of the tube are found to contain cheesy material—remnants of the old purulent accumulations.

As regards the nature of the streptococcus it differs from the gonococcus.

Infection with this organism, usually occurs during a badly conducted case or after an abortion, or is introduced into the uterus by dirty instruments in the hands of the physician.

As the inflammation of the tube progresses, the adhesions become more dense, and finally the tube becomes closely attached to the posterior surface of the broad ligament, to the uterus, to the pelvic wall and floor, and covers in the ovary with its mesosalpinx also the rectum is liable to be involved in the adhesions. The weight of the large pus tubes causes a sagging until finally they are found in Douglas cul-de-sac.

*Symptoms.*—The symptoms vary widely according to the stage of the disease and the variety of the infecting organisms. During the acute stage lasting a week or longer, the patient often suffers

intense pain, she lies in bed with knees drawn up and an anxious expression on her face. The elevated temperature, quickened pulse, and local tenderness all point to an inflammation localized in the pelvis.

The diagnostic symptoms between streptococcus infection and gonorrheal. The former dates from a confinement, an abortion, or local treatment of the uterus. The onset is rapid, attended by a chill, high fever, and a rapid pulse. The patient is bed-ridden from the very beginning of the attack, while the patient with a gonorrheal infection may only be bed-ridden for a week or 10 days, or not at all.

After the acute attack has passed in both the gonorrheal and streptococcus infections, the patient may get out of bed, continuing to suffer, but in the streptococcus cases, she usually has a septic temperature and peculiar anemic look of a grave infection.

Obstinate constipation is sometimes found as a result of the pain on straining at stool, or due to the pressure on rectum contracting the lumen of gut.

Frequent urination is often a distressing symptom. The bladder and ureters may become infected by the organisms passing into them.

*Diagnosis.*—A vaginal examination shows that the uterus has lost its natural mobility; sometimes it is solidly wedged in between masses which are felt on one or both sides of the cervix as dense, hard, shapeless, resisting bodies. The hardness of the vaginal vault is one of the most characteristic signs of the presence of pus. The position of the fundus often cannot be outlined.

If the infiltrated mass felt on the side of the uterus or in Douglas' pouch contains pus, fluctuation may be felt best by the examining finger in the rectum, but if there is only a little pus, it is impossible to detect it.

*Treatment.*—Kelly says active surgical interference is the rule in 99 out of every 100 cases, and this consists either in letting out the pus through the vagina or in opening the abdomen and removing the sac with or without the uterus.

*Expectant Treatment.*—Rest in bed, bowels kept open, proper diet, cold and hot applications applied. This treatment is only applicable in the acute stage of the disease. Kelly lays stress on the evacuation of the pus as the simplest plan of treatment, and one involving few risks to life in suitable cases. It is accomplished by one of three avenues—the uterus, vagina or the rectum.

Through the uterus: The method is to squeeze out the pus by bimanual examination—no operation required.

Simple evacuation by the vagina without enucleation is also indicated even where the abdomen has been opened, if the removal of the adherent tubes and ovaries involve risk to life.

In such cases as these, life would often be saved by simply draining the pelvic abscess through the vagina, but in an attempt to enucleate, the shock to the system and danger of new invasion of sepsis too often sacrifices the patient's life.

In making the vaginal puncture there are three possible dangers to encounter, viz., injury to the ureter, uterine artery, and rectum. To avoid these complications the puncture is best done with a pair of scissors curved and sharp on the point—introduced on the finger posterior to the cervix of the uterus. After the scissors are introduced into the abscess, withdraw them with blades opened, which will give you a lacerated opening sufficiently wide for drainage. Were you to make this opening with a knife the possibility of cutting the ureter or the uterine artery at times might be unavoidable.

In regard to the different kinds of pus-tubes. Some take on the shape of a sausage and the adhesions to surrounding organs can be broken up without danger of rupturing the abscessed tube. After the tube is freed from adhesions it is severed from the uterus by taking out a V-shaped plug from the latter. All raw surfaces are turned in with plain, small cat gut to prevent adhesions.

The tubo-ovarian abscess is more complicated and difficult to enucleate. Often it is found to occupy the space under

the broad ligament—extending from the uterus to the side of the pelvis.

This is the abscess which most frequently ruptures when being dissected out. To avoid this danger I have devised a method, which has enabled me to enucleate six of these abscesses in succession, without rupturing any or them. The patients making uneventful recoveries.

*The operation.*—First make a free abdominal incision, in order to have plenty of room to work. The patient being in Trendelenburg position, the abdominal cavity is carefully walled off with pads. Break up all adhesions which can safely be done, liberating the uterus and abscess from the surrounding viscera. Now it remains to enucleate the abscess from under the broad ligament. This is the most trying part of the whole operation. The abscess walls are thin and friable and will frequently rupture in spite of the most delicate dissection.

With Dr. Dougal Bissell's clamp, I clamp two or more inches of the broad ligament between abscess and side of the pelvis, and with scissors sever as much of the broad ligament as is clamped. This will free and make easy the dissection of the abscess on that side. If necessary apply a similar clamp between the uterus and the abscess, including in the bite the fallopian tube and the broad ligament. After this is severed the abscess can easily be lifted out of Douglas' cul-de-sac without any undue pressure made on the friable walls during the dissection.

Before closing, I wish to lay stress on the importance of draining through the vagina if infection should occur before or during the operation. Also put the patient in a half sitting position to favor drainage and to prevent the infection from ascending to abdominal cavity.

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#### DISCUSSION.

DR. MAYBANK: I have enjoyed Dr. Baker's demonstration very much. He has told me about the operation, but I have never had the pleasure of seeing him remove one of those pus abscesses in the way he has demonstrated it. I know he has met with marked success in pus tubes and abscesses in the pelvis.

The diagnosis, I think, is very much more difficult than Dr. Baker has led us to suspect.



Occasionally we have very few symptoms even referable to the pelvis. I have known one or two cases, with loss of flesh, septic temperature,—cases of that kind which give no reference to pelvic trouble at all; the patient feels very well at times, then sometimes has fever, as high as 103° or 104, malaria or tuberculosis being suspected. In the majority of cases we do find the abdominal pain, localized probably on one side, and all the symptoms he has mentioned. It is surprising what large abscesses will result from pus tubes. I very recently saw a case where there must have been two quarts of pus in the abdomen; it had ceased to be in the pelvis, and had extended up the abdomen almost just below the umbilicus. The patient was operated on, and got well. Dr. Baker did not lay sufficient stress on the methods resorted to in protecting the general peritoneal cavity from infection. The patient is put in the Trendelenburg position the intestines are pushed well up and large gauze pads used to keep them out of the way, and at the same time shut off the general peritoneal cavity.

*I think every case of pus tubes is sooner or later a case for operation.*

DR. WHALEY: I have listened with a great deal of pleasure to Dr. Baker's paper, and the subject has interested me considerably.

Dr. Baker said that he believed in active surgical treatment as soon as the disease was diagnosed. The majority of authorities tell us that that is just the time you should not, especially in acute cases, use active surgical treatment, but to wait until the acuteness of the inflammation has passed; and they also tell us it is very seldom that these cases go on to rupture before the acute stage has subsided and the chronic stage sets in. And again, I think sometimes they never should be operated upon. The mortality from pus tubes in the City Hospital is terrific the whole year round; so much so that one of the dispensary physicians informed me he had quit sending in his cases of pus tubes to the hospital, because they all died.

As to the gonococci being the productive Agent—I believe the gonococci to produce a good many pus tubes, the majority I expect, and I think the real danger in pus tubes occurs not so much from the gonococci, as from the fact that these germs inflame the tube and weaken it, thereby allowing other germs to infect this inflamed surface. It is remarkable how soon after infection a large pus tube can be found in an individual. I know of a case that Dr. Rhett operated on that was septic six weeks after the infection occurred. This was all pretty well proved. Dr. Rhett operated on her after she had become septic, in fact did not see her until then; and there was a large tubular abscess on each side. On examining the pus from those tubes, so far as the microscope went, it was a pure culture of gonococci, the pus was just teeming with them. It is the general belief, and Kelly as well as Dudley will tell you, that pus tubes produced by gonococci are not nearly so malignant when they rupture in the abdominal cavity, as the pus tubes produced by streptococci or the colon bacillus, and it is supposed that the reason so many pus tubes get well after operation, where pus has been spilled into the abdominal cavity, or where rupture had occurred before operation, is due to their having been produced by gonococci,

that they are more or less chronic, and that an old culture of gonococci lacks the virulence of the fresh culture; and for that reason the extension of peritonitis is checked. Of course, the streptococcus, or colon bacillus, would give us a more virulent infection, and a more rabid form of septicemia. In several of Dr. Rhett's cases, in which I had occasion to examine the pus, it was found free of germs or comparatively so.

Dr. Baker spoke of being able to squeeze out pus through the uterus. Some years ago there was an extensive discussion at the Medical Club about that, in which Doctors Rhett and Edwards both participated, and they even went so far as to get specimens from the dead-house to see if it was possible to squeeze pus through the diseased end of a tube. I think they absolutely failed to do so.

DR. REES: I think Dr. Edwards did favor the idea of pus going through the tube.

DR. WHALEY: He did,—they tried it by means of these specimens and it failed. I was practically convinced of the validity of their argument at that time; but recently, within the last ten days, I have had a case where this positively occurred. Dr. Baker assisted me in the operation. I operated to remove a large pus tube from the right side and we found after we had gotten into the abdomen that the tube diminished in size as we manipulated it, and it was noticed that the pus came through the vagina. The abscess kept on diminishing in size and finally became flat. On the other side was a small, broad, ligament abscess which had evidently ruptured before we had entered the abdomen and pus was found free in the pelvis.

A word with regard to conservative surgery: When we enter a pelvis in which we find pus, I think it is far better; unless we can be reasonably sure that the other tube is about to rupture, to put in a vaginal drain and drain away that pus, and get out of that abdomen as quickly as possible and close it up. My reasons for this procedure are these: By doing so you subject the patient to much less shock from prolongation of the anesthesia, and from the mutilation of tissue, and in addition to that you leave no raw surfaces through which septic material can gain entrance into the system. In this case, I simply put in a drainage tube through the vagina, did not remove any of the organs of the pelvis at all, subjected my patient to as little shock from anesthesia and handling of peritoneum as possible, and she made a nice recovery, when according to all the laws of surgery we should have expected trouble. This abscess was of good size, and extended about the whole length of the fallopian tube, being several inches in length.

Again, I would like to advocate vaginal section more often in these cases of large tubal abscesses. The vagina is the most natural approach to these abscesses, being the most dependent point, is by far the easiest place for drainage; and I think a great many of these tubes can be opened through the vagina with considerable lessening of the mortality.

As to Appendicitis and Tubal Disease: In the last *Journal* I quoted a man named Baker on this subject, in which he stated that 50% of appendices were microscopically impaired in connection with tubal diseases.

In regard to the method of excising: The method Dr. Baker has shown us, and which is advocated, is apparently a very excellent one;

but I have not yet been able to see the advantage of clamps over the ligature before cutting. In the first place you are bound to have more or less hemorrhage, no matter how careful you are to shut off the abdominal end of the arterial connection, there is a certain amount of hemorrhage taking place between these points when the ligament is cut, which is sometimes exceedingly difficult to control,—the ligature overcomes this nicely.

Again, you will find that in the majority of tubes of any size, they fall backwards instead of forward, and you usually have your tube adherent to the rectum and the posterior structures, rather than to the bladder and the anterior structures. A nice way to get out these tubes is to run your finger down behind and start pressing them up, in this way mild adhesion can be broken up, until you are able to get your tube up into the wound and do your work practically outside of the abdominal cavity, that is, in a completely walled off space.

Dr. Baker spoke of aspirating the tubes when tense. According to Jacobson, that is the very time you should not aspirate, he says to aspirate tubes that are loose and not tense. He gives as his reason that where you have tubes that are tense you have a well defined, globular, easily handled mass to deal with; but where it is loose the borders are ill-defined and it is hard to know what you are doing and where you are at.

A word in regard to abdominal gauze drainage: Years ago, at a meeting of the Medical Association at Harris Lithia Springs, I heard Dr. DaVega, a very close follower of Hubbard Price, state that in his opinion gauze never drained in the abdomen up-hill, and I believe that he was right. I do not believe that gauze will drain up-hill properly; and therefore I do not advocate drainage through the abdominal wound; unless that drainage is the cigarette rubber drain, but I do advocate drainage through the vagina where you have gravity to assist you, and where you know that drainage will be properly performed by gravity if not by capillary action.

I am very glad to have heard this paper and have learned a good deal from the discussions.

DR. HUNTER: I have listened with a great deal of interest to Dr. Baker's paper. In a recent case the sac was so thin and tense that I was afraid to either ligate or clamp for fear of rupture of the sac. I aspirated and then removed the sac.

I believe with Dr. Simons that if we have to take out both tubes and ovaries we should remove the whole organ.

DR. M. SIMONS: There are a few points I would like to touch upon, and the first I bring up is that of the etiology of pus tubes. It has become the fashion to say that pus tubes are almost always the result of gonorrhoea, or at least in the great majority of cases. I do not believe this to be the fact. I believe pus tubes may follow almost any form of endometritis. Sepsis after abortion, or after ordinary labor, is responsible for an equal, if not a greater, number of pus tubes than is gonorrhoea. The manipulations in the uterus by the gynecologist are likewise responsible for a great many cases of pus tubes.

I believe that the use of the curette, in the hands of those who do not appreciate that curetting is an operation that should be performed

surrounded by all the precautions of asepsis, is followed in many cases by suppuration in the tubes. I am inclined to believe that J. B. Murphy is a little extreme in his statement that he regards the curette as the most damnable instrument in the armamentarium of the gynaecological surgeon, but I think that curetting, performed by those who are not competent, or by those who are competent but careless in its performance, is one of the most frequent causes of septic infection of the endometrium, and extension of that septic infection from the uterus to the tubes. This I believe is not in accord with the view held by many who maintain that a very large majority of the inflammatory diseases found in the pelvis are due to gonorrhoeal infection.

The next point I wish to allude to is the diagnosis of pus tubes. The most constant symptom I believe is pain over the region of the ovaries, even in the acute cases. It is always present, and is continuous; but is much worse at each menstrual period. This dysmenorrhea is usually very characteristic. The pain is spontaneous, and elicited by pressure over the ovarian region, and by bi-manual examination. There is no more certain sign of pus tubes than pain on pressure between the two examining hands.

WHALEY: That is, with the tube between?

SIMONS: Yes; you have to reach the structures involved before you can elicit pain of that kind. It is natural to expect pain as a symptom of pus tubes, because there is always, as you have said, displacement of the tube, the tube falls backward, and carries with it the ovary, and we know of no cases in which pain is a more characteristic symptom than in those of prolapse of the ovary. Another point I would call attention to is that pus tubes may be either an exceedingly acute disease or very chronic.

I have in mind a case I operated on at the City Hospital last winter, at my first clinic. A girl of sixteen who had contracted gonorrhoea ten days or two weeks before, and when she was brought to the operating table I found pyosalpinx on one side and tubo ovarian abscess on the other. There was a general septic peritonitis. All of this occurred within ten or fourteen days of infection with gonorrhoea.

On the contrary, pyosalpinx is usually a chronic disease, and especially is it so with that form due to gonorrhoea. The majority of cases of pyosalpinx due to gonorrhoea are slow in their origin and progress. As bearing somewhat upon the treatment of these cases, I will touch very briefly upon the natural history of pyosalpinx, or rather I may say the pathology. We know that in pus tubes (or purulent salpingitis) the first step after the formation of pus is the closure of the outer ends; indeed, it is nature's effort to save the life of the individual by protecting the peritoneal cavity from infection. The manner in which the abdominal ostrum is closed is very characteristic. I allude to this closure of the tube ends to account for the occasional disappearance of the accumulations of pus in the tubes through the uterus. As long as the opening of the tube connecting with the uterus is patulous it is possible for spontaneous emptying of the pus into the uterus to take place. It is very rare, but it does happen occasionally, and the disappearance of the tumor of the tube has been observed simultaneously



with the discharge of pus from the uterus. The disappearance of the tumor can be detected by bi-manual examination. In that way the pus may empty through the uterine opening as long as that opening is patulous; when that is closed there is no longer any possibility of the tube emptying into the uterus.

This brings me to speak of the method of milking the tube that has been proposed as a plan of treatment of pus tube—which I think is most unphilosophical, not to say dangerous and unjustifiable.

As Dr. Baker has said in his paper, generally when the tubes are distended with pus the walls become thin; and under such circumstances nothing would tend more strongly to rupture than the process of milking the tubes.

Now, as to Dr. Baker's method of enucleating or shelling out the pus sac: I do not think that the cases he reports and the one I saw him operate upon were pyosalpinx pure and simple.

All of us who have seen pus tubes know that they occur in different forms; sometimes they are sausage shaped, or coiled up around the cornua of the uterus, with no adhesions to other parts. At other times we find them firmly bound to the floor of the pelvis as well as to the lateral walls or rectum. Again, we find what are known as tubo ovarian abscesses. I am satisfied that the case Dr. Baker operated on when I was present was a tubo ovarian abscess.

In chronic salpingitis the inflammatory process usually in time extends to the ovary, and some of the forms of chronic ovaritis are produced. Follicular cysts of the ovary usually result from chronic inflammation.

Pyosalpinx and follicular cyst in the ovary often occur together. The pus tube by its weight sags downward between the layers of the mesosalpinx, burrowing between the layers of the broad ligament. The tissue intervening between the cavity of the tube and the cyst in the ovary may be absorbed or perforated and the two cavities will be thrown into one, forming a tubo-ovarian abscess. Practically, then the tumor is intra-ligamentous, and it is possible to enucleate it according to the method proposed and practiced by Dr. Baker.

As to Dr. Baker's operation in the case that I saw the result was brilliant. The operation was performed after careful consideration, and after we had previously opened one of the pus accumulations through the vagina, where we could detect fluctuation. We did this with the distinct understanding that we would have to go back into the abdomen. It was not more than three weeks that this anticipation was realized. We opened the abdomen and found a tubo ovarian abscess. Dr. Baker clamped off the broad ligament on the right side, not because it was the best way of stopping hemorrhage, but because it was the way to facilitate the operation on a woman in a desperate condition, whom we were afraid to subject to the shock of long continued anaesthesia, and we desired to conclude the operation as quickly as possible.

There was one point in his operation the doctor did not lay much stress upon, that struck me as important and risky.

The tubo ovarian abscess had grown up and separated to a great extent the layers constituting the utero vesical folds of the peritoneum. After having cut through the broad ligament on the right side close to the pelvic wall, he then made

an incision through the utero vesical fold and enucleated the tumor from the front, introducing his fingers between the layers.

The operation proposed by Dr. Baker is not applicable to the majority of cases we see, in which the pus tubes are not included between the folds of the broad ligament. These are the cases in which the ordinary methods are competent.

Dr. Baker says that he employs ventral suspension of the uterus when he finds it necessary to remove both ovaries and tubes.

I think that if I had a case of double pyosalpinx and should remove both ovaries and tubes I would not leave the uterus suspended. I would not leave a functionless organ, but would complete the operation by a hysterectomy; the uterus would no longer be of use, but might give trouble further on by persistence of an endometritis.

As to operations for pyosalpinx I believe there are some rare cases, in which vaginal puncture is justifiable. I cannot believe it is justifiable, unless the pyosalpinx has become adherent to the vault of the vagina.

Indiscriminate evacuation of collections of pus in the pelvis by way of the vagina has resulted in a great deal of harm. The abscess being usually of vital origin often persists indefinitely. Intestine, ureters, bladder, and blood vessels have often been injured. I believe, however, it is justifiable where a point of distinct fluctuation can be distinguished in the vagina, and it can be ascertained satisfactorily that the pyosalpinx has become amalgamated with the vault of the vagina.

We know that one way by which nature empties such tubes is by the softening and gradual absorption of the abscess wall into the vagina. Even when the pyosalpinx is opened in this way, though you enlarge the opening leading into the cavity and pack it, sooner or later there will be a reaccumulation of pus in the tube, or the results of the subsequent contraction will produce later on just as unbearable a condition as there was before, and you will finally have to open the abdomen, break up the adhesions and remove the tubes.

I dislike to disagree with so great a surgeon as Jacobson, as quoted by Dr. Whaley, that pus tubes, if let alone, will get well. That is not analogous to the history of pus collections in other parts of the body. We know that it does not empty itself except in very rare cases. It seems probable that if the woman survive the dangers to which she is exposed from a pyosalpinx, the tumor may in time become converted into a hydrosalpinx. The pyosalpinx may in time become inert so far as inflammatory action is concerned, the pus may become sterile and it may resemble a chronic abscess elsewhere—but active inflammation may be excited in it at any time. It is a constant menace.

The progress of salpingitis is beset with danger, and rupture with fatal peritonitis may occur at any time with the slightest cause. From what he has said I think Dr. Whaley has misunderstood me. When I say that it is an unphilosophical plan to attempt to squeeze out pus through the tube into the uterus. I look to that as a plan of treatment before the abdomen is opened, and you do not know what the condition in the pelvis may be, or in other words, I do not think it is justifiable in a case of pus tubes for the surgeon as a first effort at treatment to

endeavor to squeeze out the pus from the tube into the uterus.

I think it was justifiable for Dr. Whaley when he found, during his operation, the pus going that way to facilitate its escape in that direction rather than have it escape into the cavity of the abdomen because he had it then under his fingers.

As to Dr. Whaley's case where he found the pus oozing from the abdominal ostium of the tube, I think that is simply evidence that nature had not finished her conservative work in the effort to close the tube. It did not leak at first, but did so after he commenced to handle the tube. This is not an argument against the observation that nature does close the tube as a conservative means.

DR. AIMAR: There is no question that this is about the most serious disease with which a gynecologist has to contend, and it is a disease in which no one seems to have done anything towards the prophylaxis. If we consider the etiology of the trouble, I cannot agree with Dr. Simons' views about the gonococci. Dr. Baker has quoted Sanger, as quoted by Kelly, in giving 33% of cases in which the gonococcus has been found. But Kelly further states in that paragraph that he thinks that the gonococcus is probably found in a greater number of cases than this; that in many of these cases of Sanger, sometimes the pus was examined, but, due to imperfect microscopic technique diplococci were taken for gonococci, and he would lead us to infer that the frequency is very much more often than Sanger has stated.

Baudler, of New York, who possibly goes to the other extreme, says it is much more frequent than this. He places it at 98.9%, and with that enormous proportion of cases due to this germ we have done nothing with regard to preventing the disease. It seems as if some steps should be taken in some way to prevent innocent women from being subject to this infection. We have all of us in our practice had experience where this disease has resulted very soon after marriage, the man at the time of his marriage having gonorrhea.

In regard to the statement of Dr. Whaley as to the dispensary physicians: My experience has been that in the hospital the mortality in these cases is very great, but it is due to the fact, I think, that the cases come in very late, and when they get to the hospital have been almost *in extremis*. The hardest cases I have ever operated on have been those that I have seen in the hospital. Then again, a certain number of cases refuse to go to the hospital, and somehow they do get well. In the case of two negro women, I made the diagnosis and they refused operations, and both got well. But I hope the dispensary physicians will be made to send them in early rather than not at all.

Dr. Whaley and Dr. Simons have referred to Dr. Baker's operation, controlling hemorrhage, protecting the tube and so forth, but, as I understand the operation, the most important point is to get the tube out without rupture,—the success in these pus cases is to get the sac out, while those cases that die are cases where the pus is spilled in the peritoneal cavity,—if you remove the tube whole, that lessens the mortality.

Vaginal drainage has been alluded to, which is absolutely correct, but there are certain cases to which I certainly do believe the old time hand-

kerchief bandage is applicable. In a case that is accidentally ruptured, and everything emptied and where there is a quantity of broken down, gromous, infected tissue in the lower part of the pelvis, the handkerchief bandage, well packed in, prevents the intestines from coming down against that infected surface, and prevents the infection from spreading by continuity. These cases, of course, are few, and I don't think I would use the gauze packing now as much as I did formerly,—but I believe there are cases where it is applicable, for these reasons.

DR. CATHCART: In regard to the sources of infection, I do not know whether I misunderstood the Doctor or not. I understood him to say there was only one source of infection in these cases, viz., directly through the vagina and uterus. There are four sources or avenues of infection to the tubes: First, directly through the vagina and uterus; second, through the intestinal tract, adhesion having been formed between the intestines and tubes they become permeable from an ulcerated process and permit germs to enter through the fimbriated end; third, through the blood or lymph channels; fourth, from operations opening the peritoneal cavity, when some infection may be carried in.

All cases of pyosalpinx originate from a salpingitis. Salpingitis may be acute or chronic; some cases are chronic from the first. The inflammation extends from the end of the tube, the muscular coat becomes elongated beyond the fimbriae, which retract and become invaginated into the tube, thus closing the abdominal ostium, which is the most frequent occurrence; or adhesions may be made between the tube and neighboring organs, such as the uterus ovary, broad ligament or intestines, the ostium being closed by this process. The abdominal ostium being closed the process goes on, and you have pus formation. I was at one time prone to disbelieve that the tube could empty itself into the uterus, but I have had some cases of pyosalpinx which refused operation in which the tube undoubtedly emptied its contents into the uterus, and by reference to most of the authorities I find that all of them claim that the tube at times empties itself into the uterus, when the ostium at the uterine end of the tube has not been occluded. If the uterine isthmus becomes occluded, distension of the tubes takes place, and you have a pyosalpinx, a hydrosalpinx or a hematosalpinx, according to the nature of the contents. In some cases after a time the virulence of the organism in the tube becomes lowered from want of proper food and oxygen, pus ceases to be produced and it becomes inert. Then it goes on to the formation of an exudate, which is distributed around the walls of the tube, and a serum is formed, a great deal of which is absorbed. This is the second stage of a chronic form of salpingitis, known as hydrosalpinx. Then you may have a hemorrhage causing what is called hematosalpinx. Then on to the fourth stage. It becomes attached to the ovary, the ovary is surrounded by capsule of inflammatory tissue, degeneration takes place, and a point between the ovary and tube breaks: thus you have, as Dr. Simons explained, a tubo-ovarian abscess.

These four stages of salpingitis are all forms of the same disease, and all four stages may occur in the same woman at the same time. The majority of authorities give gonococci as a



chief cause, or the most frequent cause of pyosalpinx. The five principal pathogenic germs that produce salpingitis, or that cause the infection, are the gonococcus, the streptococcus, the bacillus tuberculosis, the staphylococcus and the bacterium colicomunis.

In regard to the operation: I believe the best operation is by careful dissection, when it is confined principally to the tubes, no matter how large the tubes are, if they have not ruptured or leaked into the surrounding tissues. If they go on to the extent of breaking down, or have leaked into the surrounding tissues, these become infected, and you have a collection of pus in the folds of the broad ligament, then I would think the operation of Dr. Baker all right. Preferably I would drain through the vagina, as he did at first, hoping to get back into the abdomen at some later day. I believe with all pyosalpinx, when confined to the tubes, that the best operation is, after the abdominal incision has been made, to push all the intestines possible up towards the diaphragm and hold them there by packing with gauze sponges, seek the fundus of the uterus, and gradually with your finger dissect along its posterior surface until the cul de sac has been reached. From this point separate the adhesion from the center as much as possible, filling the space made with gauze sponges. Separate the adhesions of the intestines, and push back towards the diaphragm out of the way, packing them with gauze sponges. Now gradually separate the adhesions, holding down the tubes, beginning at the uterus and carrying it well out towards the sides of the pelvis, realizing that these adhesions are caused by an inflammation set up by infection rather than a trauma; that you have nothing there but adhesion of inflammatory lymph, which breaks down usually very easily under your fingers. During this procedure the uterus should be lifted up as high as possible with forceps. The dissection in this way is carried out to the sides of the pelvis, and, after all adhesions have been separated, excise the tube by a V-shaped incision at the cornu of the uterus, then ligate according to the manner of Dudley or Price. Ligate your ovarian artery near the pelvic end of the tube, then close in to the uterus at the anastomosis of the uterine artery, before you cut through the fold of the broad ligament. After this close in all raw surfaces with a running stitch.

In regard to hemorrhage, I have had cases in which the tubes had ruptured or leaked, and there was a large collection of pus on the sides or behind the uterus, a large pelvic abscess, in which it was not necessary, in dissecting out the cavity, to ligate any of the vessels; in fact the tissues were too rotten to hold a ligature. I think Dr. Rees will remember the case in which there was not a ligature put, but only gauze packing, and there was no hemorrhage, the patient recovering. In these cases, if necessary to drain, I would rather drain through the vagina.

DR. REES: This subject was started as early as 1783, when Dr. Seldel, a Russian surgeon, made the observation that an abscess would sometimes, following abortions, form in the pelvis, and that the Fallopian tube was filled with pus. He made an operation and opened the pus sac. His technique is interesting, and embraced some of the modern methods employed in dealing with these cases.

In 1872 Dr. E. Noeggerath wrote the first paper on latent gonorrhoea in the male infecting women. Again in 1876 Dr. Noeggerath gave another paper on latent gonorrhoea, more fully setting forth his belief that this was the cause of infection in the Fallopian tubes and pelvic structures. About 1881 Dr. Tait began his operations for pyosalpinx, determining that pus in this region could be, and should be, evacuated just as would be done for pus accumulations in any other part of the body. The views of Dr. Tait were immediately taken up and he had many followers. There was a wide field for active surgical investigation. In a few years the question was about settled in the treatment of pus in the pelvis with some minor differences in operative technique. Infections in the pelvic structures were believed to be of the pelvic cellular tissue. Careful observation, and abundant clinical experience upon the operating table, clearly settled the question that the infection was primarily in the Fallopian tubes, and the pelvic peritoneum secondary. The question of, salpingitis, pyosalpinx and pelvic peritonitis, we find but few recent writings upon. This subject has been more thoroughly settled than any other surgical condition we have to deal with, appendicitis not excepted. The diagnosis as Dr. Maybank has said, is sometimes difficult. In the majority of cases the diagnosis should not be difficult. There is a characteristic difference from any other pelvic lesion, which should generally lead those of experience to a correct diagnosis. Many cases are so extremely sensitive—the pain intensely acute and unbearable, an anaesthetic is requisite. Where there has been extensive peritoneal inflammation, with anaesthesia the distended tubes, even though they be large, cannot be determined as such. But the fixation of the pelvic organs, with a boggy and sense of deep suppuration, leads invariably to pus. The operation for pus tubes and pus sacs outside of the Fallopian tubes offers many difficulties, and a variety of pathological conditions which can only be overcome by clinical experience. The mode of attack must be determined by individual cases. I like the technique advanced and practiced by Dr. Baker. First and of great importance, a long incision to give abundance of room through which to deal with the numerous and varied adhesions found in the pelvis. The care with which the abdomen is protected away from the infected area is not the least important part in the technique. Methods of protection by gauze packing, is many times only incorrectly, improperly and imperfectly made. A mistake frequently made in these cases as in other pelvic and abdominal lesions by those inexperienced, is immediately after the abdomen is opened, to proceed with that which to first presents. Consequently the operator in a few moments is hopelessly lost in a mass or masses of distorted loops of bowels densely adhered together. A fundamental principal of surgery is overlooked: first find what the operation is made for, then determine the extent, and a plan of attack. A fair proportion of cases are admirably suited for the method followed by Dr. Baker. In large tubo-ovarian abscesses, without leakage of the tubo-ovarian sac. When there has been a leakage of the tube with secondary abscess cavities in the broad ligament or an abscess between adhesions of the bowel and tube, or tube, uterus and bowel, the abscess sac cannot be ablated by the

method advocated. Again, as Dr. Whaley has called attention, the distended pus tube has fallen posterior and become firmly adherent to the rectum, the anterior rectal wall making a part of the abscess cavity. These cases cannot be dealt with as Dr. Baker has advocated. In old cases where the adhesions are dense, I regard the operation an extremely difficult and tedious one. Dr. Whaley has called attention to drainage of pus tubes into the cavity of the uterus. Dr. Baker also mentions this in his paper. With a fair experience, and with special attention given to the uterine end of a pus tube, after its removal, I have never been able to reconcile myself to believing that it was possible for pus to drain out of this end. The protection against such drainage was always most carefully and thoroughly provided against. But such experience as Dr. Whaley has given us is most valuable, and cannot be questioned when it occurred at the time of operating under his eyes with the relaxing tube in his fingers. Pus tubes, like appendicitis, are always interesting. We have not touched this subject for a long time, in all of our surgical discussions, and it is a good thing to go over it. There is always an abundance of valuable experience left for interesting discussion.

DR. BAKER: I want to thank each one for the free discussion of my paper, and especially do I appreciate the favorable allusions to my operation. As the evening is so far advanced I will not consider further the points that have been raised by the discussion for fear of detaining you too long.

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#### SOCIETY PROCEEDINGS: ORANGEBURG.

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The third regular meeting of Orangeburg County Medical Society was called to order by the President, Dr. W. L. Pou, Oct. 2, 1905. Fifteen members answered to the roll call. The minutes of last meeting were adopted with one exception, which, upon motion of Dr. Lowman, was that the regular meetings be held on the third monday in each month, instead of first monday. After some discussion, there was a unanimous vote in favor of the third monday, and the minutes were ordered adopted with this change.

The names of Drs. J. H. Price, W. W. Wolfe, and T. H. Dreher were then presented to the society, and these gentlemen received unanimously as members. No one presenting any clinical cases to the Society, the subject was passed.

Under the head of papers and discussions, Dr. Able said he would take the liberty of calling upon Dr. M. G. Salley for a talk upon any topic he might choose.

Dr. Salley then called to the attention of the Society the use of Syr. Hydriodic Acid in treatment of typhoid fever. Dr. Salley said:

As far as I know the use of Syr. Hydriodic Acid in treatment of this disease is original with me. My attention was drawn to this drug by reading a paper by Dr. Wilcox, of New York, upon its beneficial effects in the treatment of bronchial troubles and throat affections where an eliminative action was indicated. Realizing that in typhoid fever the morbid anatomy shows specific changes in the lymphoid elements of the bowel, with a beginning hyperplasia of the glands of the ileum, which will reach its height about the 8th or 10th day; and either result in resolution or necrosis, these changes being produced by the localization of the typhoid bacilli in these glands. The bacilli pass through the bowel wall, producing necrotic tissue and liberating toxins. It seemed to me that on account of the combined antiseptic and alterative action of hydriodic acid, especially upon mucous surfaces, this would be a good agent to meet these conditions. I have not been disappointed in its use, for in the treatment of over three hundred cases with syr. hydriodic acid alone, I have had a mortality of 1%. It should be begun early and the clinical evidences of its good effect are seen in two or three days after beginning its use. A tongue that is dry, drawn together and pointed will become moist and flatten out under its influence. The bronchial symptoms which are so marked in some of these cases are markedly modified; the temperature usually stays within bounds, and the general course of the malady made milder. Of course, I practice as a routine procedure the daily washing of the rectum, to prevent fermentation, and the skin is kept scrubbed and clean. If the temperature at any time needs reducing I use cold water as a preference, but if I cannot get intelligent co-operation from the attendants and am without the services of a trained nurse I resort to the coal tar derivations. I never use the ice pack, sometimes I rub with ices. I prefer phenacetine to acetanilid in these cases. I only use them in cases where there are no untoward effects, where the lips have a good healthy color and there is produced no blueness or signs of depressed circulation. I always give the initial dose of calomel in my typhoid cases and let twenty-four hours elapse before commencing the syr. hydriodic acid. The acid is given on an empty stomach in teaspoonful doses of two teaspoonfuls every four hours while the patient is awake. I never disturb a patient in a normal sleep to give medicine. Great care should be exercised in the preparation of the acid. It should be made fresh with glycerine, and if the slightest tinge is noticed it should be discarded, as the free iodine will act in an irritating manner. In all these cases the mouth should be kept scrupulously clean by the use of some mild antiseptic and frequent rinsing, and the attendants instructed concerning the infectious nature of the disease, and absolute cleanliness insisted on in the sick chamber.

Dr. J. D. S. Fairev gave his experience in the use of  $H_2O_2$  in the only case he had used it. Lady about 66 years, previously healthy, weighed about 200 lbs., was taken with virulent



attack of typhoid fever. After ten days the morning temperature would run 104°. Afternoon 105°, pulse 140, resp. 30. Dr. D. D. Salley was called in consultation and we started syr. hydriodic acid. Forty eight hrs. previous she had had seven hemorrhages from the bowels and forty-eight hours after commencing the acid her temperature never went over 101°. There were no more hemorrhages, pulse came down to 90, and patient was dismissed two weeks afterward. Cold pack and coal tar derivatives had no influence on the temperature.

DR. M. G. SALLEY: I do not think this should be taken as a typical case by which to judge of the use of the acid; for patient who has had seven hemorrhages is either going to recover or die without drugs. The time to start treatment with the acid is early and it takes from forty-eight to seventy-two hours to see its effect. I will state here, that judging from the mortality reports in other communities it is my opinion that we have a milder type of typhoid here than is generally found.

The Chair then called upon Dr. A. S. Hyrick for his experience with syr. hydriodic acid in typhoid. Dr. Hydrick said in part:

Typhoid fever is a specific disease for which we have no specific remedy. The typhoid bacillus produces the fever and then the toxins keep it up. I presume we are all familiar with the clinical features of the disease and shall not dwell on them. In this section of the country nearly all of our acute infections are tempered by the malarial infection, which we all more or less have, and the damage left by this infection is prominent in our cases, it being doubtful if the liver affections from malaria are ever fully remedied. Upon Dr. Salley's suggestion I have used hydriodic acid in typhoid, recognizing the fact that iodine stands third in the list of malarial antidotes. If you should get hold of a preparation that is reddened, it will act as an irritant and produce diarrhoea. If this becomes persistent I use bismuth. The intestinal tract should be washed out daily, leaving the tube in the rectum so that the water may return slowly, thereby preventing the straining and tenesmus caused by a more rapid return. The mouth is kept clean, the bedding changed frequently and skin kept active. I prefer cold water for reduction temperature where there is a trained nurse; but where one cannot be had I use coal tar derivations.

Recently I have been using acetozone water with very gratifying results, being able to report 26 cases under its administration without a death. Sometimes I find a patient who refuses to take acetozone, because it nauseates them. I know of no drug to take the place of hydriodic acid, and I find my patients after its use with a better "getting up" which I attribute to the eradication of any malarial taint. I make it a point also to instruct the nurses as to mode of transmission, and insist on washing hands and disinfection of stools and urine.

I use salol only where there is a tinging of the conjunctivae on account of its diluent effect on bile. In cases treated with hydriodic acid you never find that bronchial irritation and hypostatic congestion that is marked in some cases of typhoid. I have found acetozone, hydriodic acid, sulpho-carbolates to be our best intestinal

antiseptics in the order named. I only use turpentine where I fear a hemorrhage. I use it to improve the blood condition. The ulcers rarely eat into an artery, but there is a general oozing.

DR. ABLE: I am greatly gratified for the privilege of hearing this instructive discussion and want to thank the gentlemen for the subject chosen. In our section we are comparatively free from typhoid fever; but in the cases I have treated I want to bear testimony to the efficacy of the sulpho-carbolates and good nursing. With this combination and the addition of turpentine at the end of the second week my cases usually run smoothly. Just another point on which I wish to lay stress and that is to bury the discharges and keep the dishes separated.

DR. DOYLE: My experience has been that the best treatment for typhoid fever is not to let it happen. For the past three years thanks to the efforts of Drs. D. D. Salley and Hydrick our City instituted the Manchester pail system, and we have been remarkably free from typhoid invasions. In the past six months we have had in our limits only five cases of typhoid fever, and three of these were imported. In my cases I use turpentine, guaiacol, ol. eucalyptol and ol. cinnamon, given in capsules. I never use the cold pack, but bathe with warm water. Sometimes we find that after the fever is down the temperature will hop up suddenly. I then give calomel in small doses.

DR. BOWMAN gave the history of his own case, where he found that after typhoid he was having pernicious chills which persisted until he took Warbury's tinct, and opened the emunctories, which put him on the road to recovery.

DR. BROWNING said that he had had experience with one case of typhoid under the use of syr. hydriodic acid and had found it efficacious in that one. There was a marked absence of tympanitis.

DR. POUL asked Dr. Hydrick about his diet in typhoid.

DR. HYDRICK: I enforce liquid diet, especially milk, in different forms. I always look after the milk supply and see that it is guarded. We have found liq. peptonoids to act well, that preparation with the creosote being better borne than the plain; but I prefer food prepared at home.

DR. DOYLE suggested junket ice cream where milk disagreed.

Upon motion of Dr. Jeffords the meeting adjourned with the subject of Fevers and the uses of Veratrum left open for next meeting.

## COUNTY NEWS.

### Abbeville.

ABBEVILLE, S. C., Nov. 7, 1905.

The members of the Abbeville County Medical Society held their regular monthly meeting Friday, Nov. 3, 1905, in the office of Dr. Gambrell.

Six or seven clinical cases were examined and the discussions on the cases were very interesting and beneficial to all present.

After finishing with the clinical cases Dr. G. A. Neuffer read an interesting paper on "The Therapeutic Value of Atropine in the Treatment of Intestinal Obstruction and Appendicitis." This paper led to a general discussion of the uses of atropine, and it is to be hoped that we will soon have similar papers on other drugs in daily use. The Abbeville Co. Medical Society has met once a month regularly since last March, and the attendance has improved with each—the doctors on the borders of the county especially showing increasing interest.

Every man in the Society is doing his part to make it a success, and to-day there is a better feeling existing among the doctors in this County than at any time during the past twenty years. This improved condition has been brought about by the frequent meetings of the Society, which gives the members the opportunity of knowing and understanding each other better.

We now feel that we are in a position to accomplish something, as the following case will show:

A few years ago our County Board of Supervisors saw fit to reduce the fee for examining lunatics from five to three dollars. At our second meeting we passed a resolution requesting the Board to restore the fee to the original amount. We sent a copy of this resolution to every doctor in the County and to the County Board of Supervisors, and after a short delay, with a lunatic on their hands, they did as we requested and we have had no further trouble.

At each meeting we have had a number of clinical cases to consider as well as a good paper on a timely subject. After the business is concluded we go in a body to the hotel where a sumptuous dinner is served, and here our older brethren usually keep the crowd in a good humor with their jokes and experiences that never grow old.

At our next meeting, Dec. 1st, we expect to have District Councillor O. B. Mayer, of Newberry, with us, and quite a number of invited guests from other counties in this district.

C. C. GAMBRILL, Sec.

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### Spartanburg.

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The Piedmont Sanitarium—a new institution—has been opened in Spartanburg for the treatment of nervous diseases, chronic invalids and convalescents with Dr. R. M. Dorsey as Resident Physician. Dr. Dorsey has had an extensive experience in this class of work, having been connected with a large Sanitarium near Baltimore, Md., before coming to Spartanburg.

An institution of this kind is needed in this part of the State where the climatic conditions could not be surpassed. It should merit the support of the medical profession at large.

O. W. LEONARD, M. D., Sec.

## NOTES AND REVIEWS.

### SURGERY.

T. P. WHALEY, M. D.

#### CERVICAL RIB WITH RESULTING GANGRENE OF THE FINGERS.

In the Proceedings of the Phil. Med. Soc., June 30, Sept. 30, 1905, W. Wayne Babcock reports a case. He takes issue with Murphy's idea that the gangrene is due to compression of the subclavian artery, and attributes this result rather to the angulation of the vessel produced by the additional rib, and suggests the following points:

1. Ligation or continuous obstruction of the subclavian usually results in the rapid formation of a collateral circulation, while in the ischemia, resulting from the presence of a cervical rib, there seems to be little or no tendency toward the formation of a collateral circulation.

2. Compression of one of the larger vessels of the neck usually produces a bruit which is here absent.

3. The aneurysmal enlargement or widening of the subclavian external to the rib is not in accord with a proximal point of compression.

4. In the present case the brachial pulse was well marked, although weaker than that of the opposite side. The radial artery was palpable, but pulseless, conditions consistent with an angulation or tortuosity of the subclavian so cutting down the heart impulse that an oscillation more than a distinct onward impulse of the blood in the involved terminal vessels was produced.

Venous disturbances do not result from cervical ribs alone. The subclavian vein passes to the outer side of the scalenus anticus muscle and so is not exposed to pressure. Upon the other hand, from edema or other forms of swelling in the neck or from exostoses upon the first dorsal rib, a resultant venous obstruction and edema of the arm are common.

The diagnosis may be easy or difficult. In the present case the presence of a cervical rib was early suspected, but was only clearly mapped out after repeated palpations. The coexistent deformity of the spine rendered it difficult to distinguish between accessory and normal ribs in the skiagram. Progressive circulatory changes increased by cold, unassociated with edema, and accompanied by some form of paræsthesia of the hand or arm are quite characteristic evidences of the anomaly.

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#### CHRONIC ULCER OF THE STOMACH AND FIRST PORTION OF THE DUODENUM.

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Dr. Wm. J. Mayo contributes a classical article upon this subject in the Oct. 21st issue of the *Journal A. M. A.*

After reciting the death rates without operation in different large hospitals, and the ridiculously low percentage of cures by medical treatment, he states that in his last 150 cases the mortality was only 3%, and in the last 81 cases of benign disease there has been but one death. As regards the relief of symptoms, he states they are "doing no kind of surgery to-day which



gives more pleasing results in properly selected cases."

He states that the method of relief which has the largest field of usefulness consists of gastrojejunostomy, uniting the jejunum to that portion of the stomach on a line perpendicular to the cardiac orifice. This is usually the most dependent portion. This is accomplished by drawing that portion of the stomach through an opening torn in the transverse meso-color.

## THERAPEUTICS AND MATERIA MEDICA.

J. L. NAPIER, M. D.

### TONSILLITIS, PHARYNGITIS.

F. P. Jones treats tonsillitis with phytolacca decandra, 10 to 30 drops (according to age of patient) to 4 oz. of water. Teaspoonful every two hours. If there is fever add aconite, bryonia and atropia. In acute or chronic inflammation of throat phytolacca alone is a specific.

20 per cent. guaiacol in glycerine to be mopped over the tonsils and pharynx, and guaiacol rubbed externally over the tonsils, is almost specific in above inflammations.

### PREDIGESTED FOODS.

To the issue of the *American Journal of the Medical Sciences* for April, 1905, Edsall and Miller contribute a research on this subject. They conclude that bean flour, in which the starch is predigested by means of a diastatic ferment, seems to be well digested and absorbed by infants and adults. An extremely concentrated food may be given in this way in fluid and partially digested form; a 20-per-cent. solution, although fluid, is practically equivalent to beefsteak in nutritive value. Its influence upon the digestive tract in infants in the cases studied was usually distinctly favorable, and its influence upon metabolism in infants and adults is at least equal to that of milk.

### CONTRAINDICATIONS TO DIGITALIS.

This drug, according to Satterthwaite, is positively contraindicated in cardiac neuroses, like the "tobacco heart" and is absolutely dangerous if there is a tendency to apoplexy. If it acts badly, the warning signs are nausea or vomiting, small irregular pulse, dyspnea and diminished urine.—*Exchange*.

### ACUTE DYSENTERY.

Buchanan gives a sodium sulphate solution (dram to ounce of fennel water), one dram four to eight times daily, continuing the medicine for a day or two after the blood and mucus disappear. He keeps the patient on a low diet of boiled milk, tyre and rice water until the stools become solid.

$\frac{1}{4}$  gr. doses of Protoiodide of Mercury repeated every two hours, until there is a free bilious discharge from the bowels. Also 20 drops adrenalin chlo., 1 to 1,000, in half ounce of water, injected into the rectum, (to be repeated if necessary), if there is much tenesmus will abort most acute attacks of dysentery.

### A NEW USE FOR COTTON WOOL.

W. Blair Bell refers to several cases in which he has used cotton wool in order to carry along foreign bodies which had been swallowed. One child had swallowed a gold brooch. The writer teased up very finely a small handful of absorbent wool, part of which he administered in milk and part in jam sandwiches; some hours later he ordered a dose of castor oil. In the morning there was a copious motion, in which were found several egg-shaped lumps of cotton wool, in one of which the brooch was closely packed.

### RECTAL ANESTHESIA.

A. Krongeline (*British Medical Journal*, Feb. 25, 1905) recommends rectal anesthesia by ether vapor, in cases of operation on the head and neck especially. The ether flask is placed in water at 40° C., and connected with a rectal tube supplied with a receiver to collect the condensed liquid ether. In two or three minutes the patient's breath smells of ether, and soon afterwards anesthesia is induced. If this is not sufficiently deep a few whiffs of chloroform may be inhaled.

## OBSTETRICS AND DISEASES OF CHILDREN.

LANE MULLALLY, M. D.

### INTRA-UTERINE INJECTIONS.

(*International Journal of Surgery*.)

Dr. Fabre, of Lyons, recommends in cases of puerperal infection the following solution:

Distilled water, 1 quart; essence turpentine and alcohol, of each,  $\frac{1}{2}$  ounce.

When the infection becomes general he advises turpentine internally and subcutaneously. Giving as much as a drachm in capsules, or the following formula for subcutaneous infection: Sterilized saline solution (7-1000) 1 quart spirits of turpentine and alcohol of each 75 minims.

He claims remarkable results.

### THE NATURE OF PUERPERAL ECLAMPSIA.

(*Jour. A. M. A.*, Oct., 1905.)

In an editorial it is noted that Harlitz has recently reviewed the work of Jurgens, who described the peculiar changes in the liver in puerperal eclampsia. That the liver of eclampsia, with the congestion, infarctions and degenerations presents a picture hardly ever seen in any other diseased condition, and that it is important to note that acute or chronic nephritis as a rule is absent.

The editorial goes on to say that many of the older theories have been abandoned and that eclampsia cannot be identified with uremia. That the theory of auto-intoxication dependent on pregnancy enjoys wide support.

That the theory of eclampsia being due to absorption by the mother of the products of foetal metabolism has many supporters, especially among clinicians.

That the theory advanced by Schmorl of Dresden of eclampsia being due to coagulative substances produced in the placenta is receiving support, and the theory is being subjected to experimental testing.

The editorial closes by saying: "It is interesting to note, however, that the placental theory of eclampsia seems to point the way to rational therapy."

#### THE AFTER EFFECTS OF DIPHTHERIA ON THE HEART.

(*Jour. A. M. A., Oct., 21.*)

Dr. Franklin W. White calls attention to the fact that in diphtheria the heart muscles and the nerves which control it are the seat of certain changes which more or less seriously disturb its functions. The signs of which have been observed at the height of the disease and during convalescence.

White says much less is known of the after effects of the poison of diphtheria on the heart. After a carefully prepared and exhaustive article on the subject, in which numerous cases are reported showing various types of the disease, he closes with the following conclusions:

1. The cardiac disturbance after diphtheria usually presents the picture of a mitral insufficiency with irregular heart action, and a few symptoms. Occasional cases have rapid pulse or cardiac irregularity without any other signs.

2. Moderate disturbance of the heart is very common after diphtheria, and in a large number of cases persists from two to six months after the original illness.

3. In many cases the cardiac lesion does not clear up in the first half year, but lasts much longer; some ultimately recover, others probably do not. The duration of the heart trouble is usually in proportion to the severity of the original illness.

4. The fact that children often have few heart symptoms after diphtheria must not mislead us as to the importance of the injury to the heart.

5. Cardiac disturbance of long duration following diphtheria may be entirely recovered from. It is not necessary to give up hope of recovery in individual long cases.

6. The treatment of this condition consists in a sufficient period of rest in bed, and then in watching the effects of mild exercise on the heart for several months at least and grading it to meet individual requirements.

#### SCHEME FOR THE SANITARY CONTROL OF THE MUNICIPAL MILK SUPPLY.

(*Am. Medicine.*)

Goler advocates establishing a bureau for inspection of milk supply for cities.

Physicians and scientists appointed by medical societies should formulate rules regulating the production and distribution of milk.

Goler says they should through inspectors regulate; 1, character of stable and feed of cattle, health of milkers and care of utensils.

2. A negative tuberculin test. 3. A bacterial standard, not greater than 10,000 bacteria per cubic centimetre.

4. A nutritive value of 12.5 per cent. of solids, of which 4% must be fats.

That the entire supply should be under one head with the power to license, and that laws be

made rendering it an offense punishable by fine or imprisonment to bring milk into city for sale that has not had sanitary seal put upon it. That until cities adopt these measures our children and ourselves will be exposed to the dangers that arise from dirty, disease-breeding milk.

#### GYNECOLOGY.

CHAS. M. REES, M. D.

#### FOREIGN BODIES IN THE UTERUS.

E. Toff, of Bucarest, (*American Gynecology*, Vol. II., 1903), in 1902, reports the following rare case: A patient 31 years of age had an incomplete abortion in the third month of her fourth pregnancy. On account of retention of the placenta and copious hemorrhages, she was curetted, and the uterus was packed with several iodoform gauze tampons which were removed on the following day. From that time the patient suffered more or less intense pain in the lower abdomen and back, with exacerbations during menstruation, the latter occurring quite regularly. In the intermenstrual periods she complained of a copious vaginal discharge, which did not yield to any sort of local treatment. Fever was not noted at any time. Toff saw the patient for the first time one year after the treatment. Examination revealed the uterus in anteversion, hard, enlarged and sensitive to the touch; the vaginal portion was considerably hypertrophied and inflamed, and a thick mucus of grayish-green color was flowing from the os. After dilatation Toff succeeded in extracting from the uterus cavity a firm, compressed and decomposed strip of gauze, 30 cm. and about 3 cm. wide. Perfect recovery ensued. The nature of the foreign body and the length of time during which it was harbored in the uterus without lasting ill-effects render this case particularly interesting. In a second case the author extracted from the uterus a sharply pointed chip of a peculiar sort of wood, which, in Roumania, is frequently used for producing abortion. Garnecki (*Deutsche Medic. Wochenscho.*, 1901,) reports a singular case in which a foreign body obstructed parturition. He was called to attend a case of labor. On his arrival at the house, the husband of the patient told him that a "tin-box" would have to be removed from the genital tract before the baby could be born. An examination showed: Woman 27 years, well developed, pelvis normal, os uteri dilated to the size of a fifty-cent piece, head presentation, child alive, membranes ruptured, uterine contractions satisfactory. Between the head of the child and the os uteri lay a foreign body, the supposed tin-box. On account of this obstruction the head was not able to dilate the os completely and a spontaneous termination of parturition seemed under these conditions impossible. Therefore, removal of the foreign body from the uterine cavity was decided upon. The box was turned until the lid came into view. The lid was then taken off and removed. It was now possible to grip the body of the box with forceps and to extract it by careful rotary movements. The box was cylindrical, had a diameter of 10 cm., and was 4 cm. high. The labor was finally ended by forceps, after two dense fibrous sears in the margin of the os uteri had been incised. The child



was alive and fully developed. Puerperium was normal. On inquiry the patient gave the following remarkable explanation for the introduction of this box: When 12 years of age, her menstruation appeared for the first time. In order to prevent a subsequent hemorrhage she introduced this box, in which she kept pins, into her vagina. Nevertheless, menstruation was always regular. Later she tried to remove the box, but did not succeed. She never consulted a physician, and never experienced any inconvenience. She married at twenty-five. Coition was never interfered with and the husband was unaware of the existence of the box up to this confinement. When married five months she had a miscarriage in the fourth month of pregnancy. Up to this time she had always felt the box in her vagina, but after the abortion, to her surprise it had disappeared. She was not able to explain the fact to herself, but was certain the box had not fallen out. Thus it is beyond doubt the box subsequent to the abortion slipped into the uterine cavity. It had been in the vagina thirteen, and in the uterus one and one half years without producing any noteworthy disturbance.

#### RETROFLEXIONS OF THE UTERUS.

Kovwer (*Fentrablatt für Gynä-Kologie*, 1903,) found 239 cases of retroflexion in 2,800 gynecological cases (8.5 per cent.) of which 210 were treated. In 135 the uterus was movable, and in 75 adherent. Of the latter only 7 were operated upon, the remainder being treated with tampons. Thirty-one patients were subsequently able to wear pessaries; 25 per cent. were cured. One hundred and twenty cases of movable retro-displacement were treated with pessaries; in 6 no treatment was necessary, and 9 patients operated upon, 10 per cent. were cured. Only 16 out of the 239 patients (6 per cent.) were operated upon. Alexander's operation was preferred in movable retroflexion, 9 operations being recorded with 6 cures. The writer notes in the 5 abdominal operations for adherent retrodisplacement not a single patient was permanently relieved. He is entirely opposed to the surgical treatment of retroflexion, since by no method can the uterus be restored to its normal position. This is possible in some cases by the use of pessaries. Young girls should be treated as little as possible.

Dr. Henry C. Coe, of New York, remarks on the above:

"The frank pessimism of this writer is in striking contrast with the enthusiastic reports of most surgeons. In fact his skepticism is so avowed to awaken the suspicion that he is an extremist. Between the views of those who denounce the use of pessaries and the opinions above expressed, there is certainly a middle course which is safer than either extreme."

#### LARYNGOLOGY AND RHINOLOGY.

W. PEYRE PORCHER, M. D.

##### "THE OCULAR ORIGIN OF MIGRAINE."

In the multitude of counsel there is wisdom, but when such a variety of etiology is ascribed to very similar symptoms in the same organ, to arrive at the true causes a mind is required

"Which can distinguish and divide a hair twixt north and northwest side."

Just herein therefore lies the supreme talent of the physician. To be familiar with the results obtained by surgeon and specialist, to sift out that which is premature, illy digested or spurious, and to use persistently and intelligently that which to his well-balanced judgment is rational, sound and according to the laws of nature.

There are unquestionably many reflex nasal phenomena in the eye, ear and other organs which we are unable to explain, as for instance, the effect of an operation in one nostril upon the eye or ear of the same side and sometimes of the other side.

In the last issue of the *Journal* of the S. C. Medical Association evidence was given of many pathological conditions, errors of refraction, etc., in and around the eye, dependant upon diseases of the accessory sinuses of the nose.

In the *Journal of the American Medical Association*, Oct. 28th, 1905, appears an article by Geo. M. Gould, of Phila., on "The Ocular Origin of Migraine," which amounts to a fierce arraignment of the medical profession and several medical journals for their failure to attribute at least the majority of headaches to refractive errors and to prescribe glasses for their correction. The impression left upon the mind after reading the article is similar to that of the small boy who has been whipped by a very indulgent father and wonders what the cause of the licking was. After the reaction we begin to think that there might have been a little headache which slipped in as a result of drunkenness or constipation or some other cause, but which should hardly be considered. We should rather harness up every mother's son and daughter with glasses to correct the refractive error irrespective of that which produced the error.

I quote here a brief extract to show the tenor of this paper:

This leaves simply headache, combined with nausea or vomiting, which, of course, should simply be called "sickheadache." But never did two patients have the same kind and degree and continuousness either of headache or of stomach rebellion, and we are landed in a farcical *reductio ad absurdum*. But the solemn neurologists do not know it, and they keep crying that any described case is not migraine, not "typical," doesn't fit in their boxes, is hysteria, nonsense, a contemptible oculist's whim. Some of these gentlemen assume the air of Mark Twain's jumping frog, make great exertions, but they never get "forrarder" by one inch. They fling a bombastic word, "psychosis," "dementia præcox," "hysteria," "neurasthenia," etc., at the poor patient, order her to the sanitarium or to Europe, prescribe bromids, placebos, or the rest-cure: they then prepare the next edition of their text-book in which ignorance of nervous diseases vies with therapeutic nihilism. If the oculist says he knows a cause and a cure for many cases, Dr. Dana will inform him that "the only real mental affection connected with eye strain is the symptom-complex with grandiose ideas on the part of ophthalmologists." Dr. Fisher will also add:

"The oculist is not expected to have such a knowledge of these diseases, either pathologically or clinically, as would make his opinion of any special value, and, therefore, his statements and opinions should be taken only in such a sense as

from his limited horizon of observation a partial understanding of these conditions renders possible."

Shakespeare and Molière in collaboration could not do justice to the antics of some of our modern neurologists, neither to some of our defunct commercial medical journals, whose ghosts are sometimes draped so realistically by their publishers that one would almost think them really medical and as much alive as the famous Mr. Partridge and his almanac. The *Medical Brief*, the *Medical Mirror*, the *Philadelphia Medical Journal*, the *New York Medical Journal*, the *Medical News*—how from their graves they hate and belabor the oculists! The *News*, even after its death, was heard to gibber that at least 20 per cent. of our citizens have gastric ulcer which the surgeon should excise at once. Think of 16,000,000 American citizens being ordered to be gastrotomized in the next 24 hours! But that, of course, is better than spectacles!

When one carefully observes this attitude of mind it becomes evident that these opposers and ridiculers are most anxious to find that the sufferers from migraine, epilepsy, neurasthenia, hysteria, melancholia, indigestion and headache are, thank God, incurable. Their fury in ridiculing the refractionist, their blindness to his truth, their immoral misrepresenting and misreporting him, their editorial malevolence, are indicative of "much." If they had a spark of true scientific spirit, they would be glad to examine a theory and the facts supporting it which might bring some light into their darkness as to the origin of "migraine." If they had the least therapeutic zeal they would like to cure some of their patients of diseases they have all admitted incurable. If they had the least pity in their hearts of human suffering they would grasp at even a slight possibility of lessening the agonies of millions of their fellow-citizens. But of some neurologists and editors of defunct commercial medical journals one scarcely expects humanity or medicine. What, then, shall be said of oculists who join them? Nothing, except to wonder what kind of refraction they are doing, not to have seen every day their patients cured of these diseases by the glasses ordered. Were there a scintilla of the true investigator's spirit in their minds they would themselves put on their own noses the glasses that we say cure these patients, and test the theory. In a week they would have all the migraine needed, at least, to reduce even them to silence. I will guarantee to produce by this laudable human vivisection experiment, in the skeptics and cynics, any desired degree of "neuritis," "migraine," "neurasthenia," "hysteria," "melancholia," "dementia præcox," "degeneration," "nervous break-down," "neurotic predisposition," "katatonic state," "major psychosis," "melancholia of involution," "psychical tonus or contracture," "forme fruste," manic depressive insanity," "confusional psychosis," "pseudoneurasthenia," "mysophobia," "topoalgia," "neurasthenical syndrome," and the rest. And all with a pair of 0.75 D. cylinders! The committee appointed must be composed of non-presbyopes and made up equally of neurologists, the editors of defunct commercial medical journals, and ultra-conservative "ophthalmologic surgeons."

There is hardly a case of severe eyestrain reflex that, viewed in the life-history, does not show

a persisting morbid cause acting on the organism, as it were, from without. Balzac said that when he did not have head misery he had digestive wretchedness, and *vice versa*. In the majority we see this cause attacking one organ after another, upsetting the normal functions of the mind, brain, stomach, liver, heart, lungs, skin or eliminative organs, and all according to the kinds of ametropia present and the amount of work demanded of the eyes. Eye-rest at once gives relief."

It is extraordinary that in an article of this character there should be no mention of many causes of eye strain and refractive errors and the advisability of removing these causes before applying glasses for their correction. Certainly every rhinologist will testify that many diseases in the nose are productive of changes in the configuration and condition of the eye; patients frequently state that their glasses which they formerly wore with comfort became too strong for them after tumors and other growths had been removed from the nose and also that the presence of abscess or inflammation of the accessory sinuses often causes myopia, hyperopia or astigmatism from an elongation or shortening of the eye ball or an alteration of the curvature of the cornea. Surely the Latin maxim, "causa sublata tollitur effectus" should be applicable here. The cause being removed we remove the effect.

#### ETIOLOGY OF CATARRH.

In the *Journal of Laryngology* for September, 1905, Dr. B. M. Berens of Minn., writes a paper on "Observations on Catarrh and Predisposition or Reflex Versus Catarrh Theory," in which he undertakes to prove that "Predisposition to functional and pathological disturbances of the eye, ear, and respiratory tract consist in the irritation of the nasal nerves which causes dilatation of the arterioles with hyperemia of the capillary system."

He says: "As a proof of this I shall explicitly state that no other mode of treatment than operative instrumental for removal or reduction of hypertrophies and cauterization for eliminating irritation has been employed in cases which I shall report."

In order to minimize the number of cauterizations, I have striven to follow the track of nasal nerves, whose fibers were involved in the irritation and sought to centralize the application of the cautery in order to be sure of cutting off conduction to the vaso-motor centers, but when we remember that the sensory and sympathetic nerve supply of the nasal mucosa forms a network of intricate and wide extent, also occupying localities anatomically difficult of access, we will have to be content with what improvement of circulation can be obtained by eliminating hyperesthesia wherever it is possible. Besides the extent of cauterization in order to prevent regeneration of the nerve, and therewith its conductivity is another problem to be solved; in short, the cauterization considered as a therapeutical agency has as yet a haphazard look.

Time and again I have been asked by fellow physicians whether I can always locate the origin of reflex congestion in the different localities. The intricacy of nerve filaments in the nasal mucosa precludes the possibility of doing this with any degree of exactness, and for this reason I have



followed the rule, which I recommended also in my former paper, to use the condition of the throat as a gauge, by which to judge whether all irritation in the nostrils has been permanently removed or not. However, as a general rule, congestion of the eyes will be due to irritation of the naso-ciliary nerve fibers, and the most hyperesthetic spots will be found in the upper part of the nostrils, both on the external and septal sides. A pressure with the probe here and still more an application of the cautery point will cause an increased congestion of the eye and lachrimation, but if the conductivity has been cut off, it will be succeeded by a diminution of the original congestion. The immediate increased congestion can be explained only as a result of the increased irritation of the central part of the nerve. The same result is to be expected if we wish to remove congestion of the ear, and is the most reliable evidence that we have hit the nasal nerve filaments, the irritation of which causes congestion of the ear. Subjectively, it has also been verified in many instances by the patient's complaint of increased tinnitus or fullness of the ear. Congestion of the ear is most marked in the upper part of the drum-head, along the manubrium and frequently in the external meatus close to the drum-head. The localities in the nostril causing reflex congestion from irritation are, as a rule, the maxillary side of the middle turbinate and corresponding part of the maxilla itself.

The author here reports fourteen cases of inflammatory conditions of the lids and conjunctiva and even intractable phlebotenular keratitis which were relieved by applications of the electric cautery, to different areas in the nose, with beneficial results."

Of the deep seated affections of the eye he says: "Of deep-seated affections of the eye I have not met with any except the one of amblyopia, which was reported in my first paper, and one of glaucoma, which was benefitted by removal of a piece of the middle turbinate.

While I am not in position from these two cases to make any strong claim for deep-seated affections of the eye being due to nasal irritation, it cannot be denied that the immediate improvement which took place after nasal treatment is suggestive of such a cause."

He next reports six cases of tinnitus and slight deafness in which more or less complete relief followed the removal of hypertrophied mucous tissues and the cauterizing of hyperesthetic areas in the nose.

"The possibility of improving circulation in the eye, ear and upper respiratory tract by cauterizing certain hypersensitive areas of the nasal fossae allows of only one conclusion, viz: that irritation of the nasal nerve fibers constitutes the main factor of causing reflex congestion; and, further, the fact that improved nutrition of the nasal tissues advanced *pari passu* with elimination of hyperesthesia proves that the underlying pathologic agency of this malnutrition can have been nothing but a reflex congestion, maintained by the paretic state of the vaso-motor centers, which superintended the circulatory system. The nasal mucosa abundantly supplied with sensory and sympathetic fibers is from earliest childhood exposed to climatic vicissitudes, and mechanical injuries of impure air, which strike those parts of the nostrils most severely, through which the

inspiratory air current passes, and for this reason we detect the earliest manifestations of hyperesthesia in the upper part of the nostrils on the septal and ethmoidal side and also on the anterior and inferior surface of the middle turbinate. Irritation once started is therefore the foundation of congestion and exudation, and a further encroachment in the nerves by hypertrophic or hyperplastic products is produced, by which the paretic condition of the vaso-motor centers is maintained.

If branches of the naso-ciliary and Vidian nerves are involved in the irritation, the important organs of vision and hearing are endangered.

In order to illustrate the fact that it is nerve irritation, which causes congestion, I shall again call attention to the experiment of causing pressure by the probe on different areas of the nostrils. Applied on an indolent spot, there will be no reflex, while pressure on a hyperesthetic spot will call forth increased congestion of the lids, lachrimation, congestion and sensation of fullness in the ear, headache, etc., symptoms which can be explained only on the theory of vaso-motor paresis brought about by increase of irritation.

The opposite experiment of stimulating the vaso-motor centers, by applying cocaine or adrenalin on the nasal mucosa causes contraction of the arterioles, congestion disappears, and returns when the effect of these drugs has passed off.

The cautery point destroys the irritated nerve filaments and the permanent improvement of circulation gives evidence of elimination of a factor which has held the vaso-motor centers in a paretic state. Consequently predisposition to acute inflammation is also removed.

The vasomotor centers being primarily involved, it follows from necessity that:

1. The theory of catarrh or primary affection of the mucosa is untenable, and also
2. The theory of inflammation by continuity of tissue.

#### THE INFERIOR TURBINATED BONE; ITS FUNCTION, DISEASES AND TREATMENT.

Phillips, in the *American Journal of the Medical Sciences*, for July, 1905, concludes his paper as follows: (1) Hypertrophy and deformities of the inferior turbinated bone may interfere with nasal respiration; (2) they may interfere with drainage; (3) they give rise to pressure symptoms and subsequently to mental depression; (4) they prevent proper intranasal hygiene; (5) true hypertrophy must not be confused with congestion or inflammation; (6) hypertrophic tissue and portions of the bone should be removed when symptoms and appearances indicate pressure, altered secretions, interference with drainage, and the normal functions of the nose; (7) escharotics should never be employed; (8) the galvanic cautery is of doubtful efficiency; (9) a clean cut by means of specially devised scissors through both soft tissue and bone is the best method of treatment; (10) the snare offers the best method for the removal of posterior hypertrophies; (11) the resulting wound should be protected with a thin layer of gauze, moistened with a twelve per cent. solution of acetotartrate of aluminum to which a few drops of weak adrenalin solution may be added.—*Extracted.*

#### MASSAGE OF NOSE IN HAY FEVER.

Denker reports that he has absolutely cured eight hay-fever victims by massage of the mucous lining of the nose. By this means he was able not only to cure an existing attack, but to prevent its recurrence in following seasons. He first anesthetizes the sensitive mucosa by swabbing it with a mixture of 1 part cocain and .01 part adrenalin in 10 parts distilled water, using a cotton-wound nose sound for the purpose. The massage is done with this sound dipped in a 10 per cent. antiseptic oil. He commences with slow, light stroking of the inferior turbinate, gradually increasing the rapidity and the pressure and passing to the middle turbinate, and thence, if possible, to the superior, returning over the mucosa of the septum. The massage is completed in two or three minutes at first and in from three to four as the patient becomes used to it. The procedure is repeated through each nostril every day, supplemented, if necessary, by instillation of diluted laudanum in the conjunctiva sac. He thinks that it is more logical to remove the cause than to attempt to combat the established affection by antitoxin or otherwise.—*Extracted.*

#### PATHOLOGY AND BACTERIOLOGY.

G. MCF. MOOD, M. D.

##### YEAST IN TUBERCULOSIS.

W. R. Huggard and E. C. Morland (*Lancet*, June 3, 1905—*Monthly Cyclopaedia of Practical Medicine*, Aug., 1905) give results of their observation of the effect of yeast taken internally in tuberculosis. In almost every case some improvement was noted. "In 5 cases, the tubercle bacilli disappeared from the sputum, and the disease was seemingly arrested. In 7 cases marked improvement took place. In 11 cases of medium severity and doubtful prognosis, all but one showed improvement. Twelve advanced cases of bad prognosis appeared to be benefited, at least for a time." The yeast is supposed to act partially by the bactericidal effect of its nuclein, and partly by its nuclein causing a leucocytosis. Several kinds of yeast were used, and given in doses of 2 or 3 grams once a day in cold or tepid milk or water. "Some patients noticed no influence; others felt a sense of well being, while a few had a feeling of exhilaration." It appeared to have no influence on the temperature of the patients.

##### THE SPIROCHOETA PALLIDA.

Antonia Fanoni (*N. Y. Med. Jour. and Phila. Med. Jour.* Nov. 4, '05), reports 15 cases of syphilis, 13 in primary or secondary stages, 2 in tertiary stage; and two (2) cases of non-syphilitic character examined by him for the Spirochoeta Pallida. The organism was found in 11 of the 13 cases of primary or secondary syphilis examined. Examinations of tertiary lesions (gummata) were negative. Both of the control cases (non-syphilitic in character) were negative. All the chancres examined (7 in number) showed spirochoeta. The spirochoeta was found also in a hypertrophic and congested tonsil in a case of secondary syphilis. "The organism was also found in the inguinal glands, in papules, in condylomas and in mucous patches." In the examination of two primary, and one secondary le-

sion, the organism was found alive in hanging drop preparations. The organism was not found in two cases which had been under anti-syphilitic treatment. He considers this as pointing to its protozoal nature, its disappearance being accounted for, on the same principle as that of the plasmodium malariae from the blood after the administration of quinine. His examinations included chancres, enlarged inguinal glands, condylomata, papules, mucous patches, gummata, material from tonsils and urinary sediments, chancreoids and large chronic ulcers of the leg were examined, for control. The spirochoeta pallida (Schaudin and Hoffman) is a delicate, long, thin, filamentous, spiral or corkscrew shaped organism, with pointed ends, very faintly refractile and markedly mobile. In size they vary from 14-10 microns in length, and .25 or less micron in width. The spiral turns are numerous and quite regular. The organism stains with difficulty, and is seen only with high powers of the microscope. The organism has not been accepted as the specific etiological factor of syphilis.

#### CORRESPONDENCE.

##### BELLADONNA PLASTER IN HERPES ZOSTER.

MR. EDITOR:—

Referring to the article by Dr. Robinson reproduced in your current issue from the *New York Medical Journal*, in which the subject of Herpes Zoster is discussed, the recommendation of internal treatment in connection with aseptic and antiseptic applications recalls an experience of my own which will probably prove interesting.

Some twelve years ago, Dr. George Walker, then of this place, now Assistant Professor of Surgery at Johns Hopkins University, had in charge one of the most severe cases of Herpes Zoster that has ever come under my observation. The eruption had extended over the entire trunk, and the suffering of the patient was intense.

After exhausting his knowledge of the treatment of this disease without appreciable results, Dr. Walker advised a consultation with Dr. Thomas W. Campbell, also of this county. Dr. Campbell recommended that the eruption be cleansed with diluted alcohol and covered with belladonna plaster. The suffering of the patient was relieved at once, and within twenty-four hours the improvement was very noticeable. A few days later recovery was complete.



Since the experience referred to, I have had numerous cases of this troublesome disease. I have used belladonna and opium plasters with uniform success. My method is to cleanse the eruption with diluted alcohol and boracic acid, and then cover the eruption with a plaster, allowing the plaster to extend a half inch, or such a matter, over the affected surface on the unaffected surface. The plaster should be applied hot to each new patch as it appears, and allowed to remain as long as it will stick.

M. J. WALKER, M. D.

Yorkville, S. C., Oct. 28th, 1905.

#### MISCELLANY.

#### CONCERNING THE GEOGRAPHIC DISTRIBUTION OF THE YELLOW FEVER MOSQUITO.

The proper consideration of this now all-important species must necessarily be divided into two sections; first, the actual present distribution of the species so far as it can be ascertained; second, the exact limitations of the regions in which, if accidentally introduced, it may reasonably be expected to propagate and to become perfectly established. For immediate quarantine purposes the first of these is the most important, but looking to the future, an exact knowledge of the regions which must be included in the second category is obviously scarcely less important.

United States.—*Virginia*: Virginia Beach. *Kentucky*: Lexington. *Illinois*: Cairo. *Tennessee*: Nashville. *Arkansas*: Hot Springs. *Louisiana*: Ruddock, New Orleans, Baton Rouge, Napoleonville, Hammond, Shreveport, Franklin. *Mississippi*: Pass Christian, Summit, Quarantine Station, Biloxi. *Georgia*: Atlanta, Pelham, Augusta, Savannah, Brunswick. *Florida*: Barrancas, Key West. *Texas*: Galveston, Houston, Victoria, San Diego, Tyler. *South Carolina*: Charleston, Sullivan's Island. *California*: San Diego, Angel Island (Carter). *Maryland*: Baltimore (Carter)—breeding in fresh water on fruit wharf. *North Carolina*: Beaufort, Winston.

From the above it will be seen that although the actual localities which may specifically be designated from the United States are comparatively small in number, and that the actual localities from other parts of the world are equally sparse, we have still sufficient facts to enable, in my opinion, a sound generalization, both as to probable actual occurrence and as to regions in which the species will readily establish if once introduced. It will be noticed that all of the occurrences within the United States, except Nashville, fall within the limits of what are known as the tropical and lower austral zones. These life zones include practically all of the southern United States which border on the Atlantic Ocean and the Gulf of Mexico, with the exception of those portions of Virginia, North and South Carolina, Georgia, and Alabama, which constitute practically the foothills of the Appalachian chain; in other words, western Virginia and North Carolina, the extreme northwestern corner of South Carolina, the northern part of Georgia, and the extreme northeastern corner of Alabama. Further than this, the lower austral zone includes the western half of Tennessee, the western corner of Kentucky, the extreme southern tip of Illinois, the southeastern corner of Missouri, and all of Arkansas except the northern portion. It also includes the southern portion of Indian Territory, southern Arizona, and some of northern Arizona, and southern strips in Utah, Nevada, and California.

In the greater part of the territory thus indicated, and where the climate is not too dry, *Stegomyia fasciata* will, with little doubt upon close search, be found.—L. O. Howard, Ph. D., in *Public Health Reports*.

#### AS TO CHANGE OF CLIMATE FOR THE CURE OF CONSUMPTION.

"Climate in consumption is a will-o'-the-wisp. It is the end of the rainbow with its pot of gold. It is ever just a little beyond. It rests in Colorado, New Mexico, Arizona, California. Like children in their simple faith, chasing the

rainbow's vanishing end and delving for treasures where once it stood, our patient pursues his phantom till, worn and wasted, weary, but hopeful still, he falls asleep and wakes to learn that the magic end of the bow of promise rests upon the mystic shores of the spirit land."

While certain climates may be preferred for certain consumptives, it is nevertheless the consensus of opinion of the leading authorities of the day that there is no climate which has a specific curative power over consumption. Many, including Dr. S. A. Knopf, of New York, an acknowledged expert on the treatment of consumption, hold that cures effected in the home climate in which the patients will have to live and work after their restoration to health are more lasting and assured than cures obtained in more genial climes. While it is known that patients cured in the salubrious regions of the West have been able to return and live in Illinois and eastern States from whence they came, it is also known that others can never leave the climates in which they recovered, for on their return to their own State their disease recurs.

There are many reasons why an attempt should be made to cure a consumptive patient at or near his own home if it be in a climate not unsuitable for the cure of consumption; many reasons why he should not be sent a long distance from home.

Separation from friends depresses the patient. "Homesickness" is a malady which often baffles the physician.

The expense of the journey is a serious drain on his resources and is often incurred unnecessarily. As has been aptly stated by the State Board of Health of Maine, "many patients could be well put on the road to recovery in their own State at a cost which would barely defray their expenses to and from Colorado and Arizona."

The fatigue of a long journey is bad for a consumptive.

The lack of home comforts in a distant State and the inability often to obtain proper accommodations unless at a pro-

hibitive price naturally handicap the best efforts made to cure the patient.

The expense of living in the States having "specific" climates is great. Even if his disease can be cured the patient may not be able to return to live in his home State.

If the patient must work he can find no occupation. Too many have preceded him.

It is known that in certain Western States doors are closed to the consumptive and legislation against him is contemplated.

For the wealthy patient, who can be surrounded by his relatives and friends wherever he goes, a change of climate may be desirable; for the poor patient—and consumption is often a disease of the poor—a change of climate frequently quickens an unfavorable termination of the disease.

The consumptives of Illinois should not forget that their disease can, as a rule, be cured in Illinois if it can be cured anywhere.

Consumption has been cured in the past and is still being cured in Massachusetts, Rhode Island, New York, Pennsylvania and other eastern and central States. Not one of these States offers special advantages in altitude, temperature, sunshine, air or soil, or other elements necessary to the successful treatment of consumption which can not be enjoyed in Illinois.

It is often not so much the best climate for the disease as the best place for the consumptive.

Before changing climate the consumptive should obtain competent medical assurance that the change will be beneficial. A climate or altitude which is suitable for one consumptive may cause the speedy death of another. An extremely hot climate is often not only more exhausting, but more dangerous to the consumptive than an extremely cold climate.

The consumptive should not go to any State without first informing himself as to the exact locality he is to visit, and the certainty of securing suitable accommodations in hospital, hotel or boarding house. A neglect to do this has caused un-



told trouble and misery to consumptives, and has resulted in the death of many unfortunates. The State Board of Health will gladly furnish any consumptive in Illinois with a list of the sanatoria and hospitals for consumptives in any of the eastern, southern or western States, with such information regarding the climate and altitude as may be desired.—*Illinois State Board of Health Pamphlet on Consumption.*

### AFFILIATED COUNTY SOCIETIES WITH MEMBERS.

(The Secretary begs to announce that this list will appear for several issues, in order to make the same as complete as possible.

He requests that he be notified promptly of any errors or omissions.)

#### ABBEVILLE.

(ABBEVILLE COUNTY MEDICAL SOCIETY.)

*Secretary, C. C. Gambrell, Abbeville.*

J. A. Anderson.....	Autreville.
J. R. Bell.....	Due West.
P. R. Black.....	Mt. Carmel.
J. B. Britt.....	Troy.
J. M. Carlton.....	Mt. Carmel.
C. C. Gambrell.....	Abbeville.
F. E. Harrison.....	Abbeville.
L. T. Hill.....	Abbeville.
J. W. Keller.....	Abbeville.
T. O. Kirkpatrick.....	Lowndesville.
D. S. Knox.....	Autreville.
Frank Lander.....	Williamston.
S. Mare.....	Anderson.
G. A. Neuffer.....	Abbeville.
W. H. Pepper.....	Anderson, R. F. D
J. M. Richardson.....	Anderson.
M. W. Strickland.....	Pelzer.
J. W. Wideman.....	Due West.
J. D. Wilson.....	Lowndesville
W. W. Wilson.....	Williamston.

#### ANDERSON.

(ANDERSON COUNTY MEDICAL ASSOCIATION.)

*Secretary, J. B. Townsend, Anderson.*

Frank Ashmore.....	Anderson.
J. L. Gray.....	Anderson.
J. C. Harris.....	Anderson.
W. R. Haynie.....	Belton.
B. A. Henry.....	Anderson.
W. S. Hutcherson.....	Anderson, R.F.D.

W. H. Nardin.....	Anderson.
W. H. Nardin, Jr.....	Anderson.
R. P. Ransom.....	Williamston.
J. B. Townsend.....	Anderson.
R. G. Witherspoon.....	Anderson.

#### AIKEN.

(AIKEN COUNTY MEDICAL SOCIETY.)

*Secretary, W. C. R. Turnbull, Aiken.*

T. G. Croft.....	Aiken.
B. S. Dunn.....	Aiken.
T. P. Edwards.....	Graniteville.
L. B. Etheridge.....	Wagner.
W. S. Eubanks.....	Talatha.
J. I. Green.....	Bath.
11. T. Hall.....	Aiken.
M. M. Lecroy.....	Langley.
W. E. Mealing.....	North Augusta.
C. F. McGahan.....	Aiken.
J. A. Millhouse.....	Perry.
V. Mott.....	Aiken.
H. J. Salley.....	Salley.
W. H. Shaw.....	Langley.
C. A. Teague.....	Graniteville.
W. C. R. Turnbull.....	Aiken.
J. R. A. Whitlock.....	Kitchen's Mill.
W. A. Whitlock.....	Kitchen's Mill.
W. D. Wright.....	Langley.
B. F. Wyman.....	Aiken.
J. F. Wyman.....	Aiken.
H. H. Wyman, Sr.....	Aiken.
H. Hastings Wyman, Jr.....	Aiken.
Harry H. Wyman.....	Aiken.

#### BARNWELL.

(BARNWELL COUNTY MEDICAL SOCIETY.)

*Secretary, L. F. Bonner, Blackville.*

L. F. Bonner.....	Blackville.
D. K. Briggs.....	Blackville.
S. R. Hickson.....	Kline.
R. C. Kirkland.....	Barnwell.
J. A. McCreary.....	Williston.
E. L. Patterson.....	Barnwell.
W. C. Smith.....	Williston.

#### CHARLESTON.

(MEDICAL SOCIETY OF SOUTH CAROLINA.)

*Secretary, J. C. Mitchell, Charleston.*

C. P. Aimar.....	Charleston.
R. Alston.....	Charleston.
A. E. Baker.....	Charleston.
L. D. Barbot.....	Charleston.
R. L. Brodie, Hon.,.....	Charleston.
A. J. Buist.....	Charleston.
J. S. Buist.....	Charleston.
J. W. Burn.....	Charleston.
R. S. Cathcart.....	Charleston.

W. P. Cornell.....	Charleston.
H. W. DeSaussure.....	Charleston.
J. Frampton .....	Mt. Pleasant.
Jno. Forrest .....	Charleston.
J. P. Galvin.....	Charleston.
J. M. Green.....	Charleston.
W. H. Huger.....	Charleston.
B. W. Hunter.....	Charleston.
H. P. Jackson.....	Charleston.
F. B. Johnson.....	Charleston.
W. H. Johnson.....	Charleston.
R. S. Kirk.....	Charleston.
C. W. Kollock.....	Charleston.
Jos. Maybank .....	Charleston.
Wm. Mazyck .....	Charleston.
A. Memminger .....	Charleston.
J. C. Mitchell .....	Charleston.
G. McF. Mood.....	Charleston.
Lane Mullally .....	Charleston.
E. F. Parker .....	Charleston.
F. L. Parker, Hon.,.....	Charleston.
W. P. Porcher .....	Charleston.
C. M. Rees.....	Charleston.
Edw. Rutledge .....	Charleston.
T. M. Scharlock .....	Charleston.
C. H. Schroeder.....	Charleston.
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	[R. F. D. No. 2.
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	[R. F. D. No. 5.
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O. W. Leonard.....	Spartanburg.
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H. E. McDowell.....	Spartanburg.
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H. B. Tate.....	Pacolet.
John O. Vernon.....	Welford.
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J. F. Williams.....	Roebuck.
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Archie China .....	Sumter.
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## HONORARY FELLOWS.

1870.....	F. L. Parker.....	Charleston.
1870.....	B. W. Taylor.....	Columbia.
1871.....	T. G. Simons.....	Charleston.
1872.....	J. C. Spann.....	Catchall.
1873.....	A. A. Moore.....	Camden.
1873.....	M. G. Salley.....	Pinewood.
1873.....	R. L. Brodie.....	Charleston.
1874.....	W. H. Nardin.....	Anderson.
1874.....	J. F. Pearce.....	Claussens.
1874.....	O. B. Mayer.....	Newberry.
1875.....	T. G. Croft.....	Aiken.
1875.....	Manning Simons .....	Charleston.

The following Counties have not yet affiliated:

Bamberg.	Georgetown.
Beaufort.	Horry.
Berkeley.	Lancaster.
Chesterfield.	Laurens.
Clarendon.	Newberry.
Darlington.	Orangeburg.
Edgefield.	Williamsburg.

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### South Carolina Medical Association.


Next Annual Meeting at Columbia, S. C.,  
April 18th, 1906.

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Editor.

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**ANNUAL SUBSCRIPTION, \$2.00.**

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THE JOURNAL is published monthly under the auspices of the South Carolina Medical Association. Members who do not receive their copies will please notify the Managing Editor at once. Secretaries of county societies are requested to send reports of their meetings, and items of news that may be of interest to the profession. Original articles are solicited. Articles should be type-written; and illustrations sent with articles will be printed at the expense of the writer. Reprints will be furnished at the rate of 75c. a page for a hundred copies.

All matter must be in the hands of the editor by the 10th of each month.

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## EDITORIAL COMMENT.

---

### OUR ATTITUDE TOWARD THE AMERICAN MEDICAL ASSOCIATION IN ITS FIGHT AGAINST THE PROPRIETARY MEDICINE AND NOSTRUM FRAUD.

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In the September issue of THE JOURNAL OF THE S. C. MEDICAL ASSOCIATION appeared an endorsement of *The American Medical Journalist* which was equivalent to an attack upon the policy of the American Medical Association in fighting the Patent and Proprietary Medicine combination. *The American Medical Journalist*, which is evidently published by, and in the interest of, the manufacturers of proprietary medicines and nostrums has taken full advantage of its opportunity, and has reprinted this endorsement and circulated it broadcast, making it appear that we have severed our allegiance to the righteous cause championed by the American Medical Association. It is a matter of deepest regret and mortification

to the editor that the item referred to should have been allowed a space in the JOURNAL by the associate editor during the absence of the former upon his summer vacation, and he wishes it clearly and distinctly understood that his policy of antagonism to nostrums and proprietary compounds has not been altered by a hair's-breadth. THE JOURNAL OF THE S. C. MEDICAL ASSOCIATION will continue to aid in the great fight, and will always rejoice to give publicity to whatever may help to remove the scales from the eyes of the multitude of physicians who are blindly aiding and abetting the gigantic nostrum fraud which attempts to masquerade in the guise of honesty and truth. We are thoroughly in sympathy with the American Medical Association and will welcome every opportunity to render whatever assistance may be in our power.

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## THE AMERICAN MEDICAL DIRECTORY.

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For some time past the General Secretary of the American Medical Association has been collecting data with the intention of publishing a biographical card index and directory which will contain the name of every physician in the United States. His report of the American Medical Association at the Portland meeting, in which he stated that the work was steadily progressing, was approved by the Committee on Reports of Officers and received the endorsement of the House of Delegates with instructions to continue the work. In order to answer numerous enquiries concerning the nature and purpose of this undertaking and explain wherein it will differ from other medical directories, an editorial was published in the *Journal* of Nov. 18, which has been reprinted and circulated in pamphlet form. From this we quote as follows:

"Detailed information in all technical lines has increased a hundred-fold in the last half century. Along practical and sociologic lines, there is little more known than there was fifty years ago. No one knows how many individuals are at present engaged in the practice of medicine in the United States. Estimates vary from



110,000 to 140,000. Of this definite number, no one knows how many are properly licensed by the licensing body of the state in which they live. In many states, owing to the condition of the records, the state board itself can not tell whether a certain individual has a right to practice medicine or not. Information obtained by one state board at considerable expense and trouble is not utilized by others. Knowledge possessed by one society is not shared with other societies. Statements regarding college and year of graduation, as well as regarding state licensure, are in many cases most difficult of verification. If one desires data regarding a physician, there is no central bureau that can furnish it to him, no general clearing-house for information. Licensing bodies are continually met by the fact that they are unable to obtain reliable information whereby they may verify statements made by an applicant. There is not in existence to-day a list of the physicians of the United States whose legal qualifications to practice medicine have been verified. Out of the fifty-four state and territorial licensing bodies, only twenty-one have ever published a list of physicians legally qualified to practice medicine within their jurisdiction.

Information regarding members of the profession is difficult to obtain when desired for identifying, locating or tracing an individual physician for personal notices, biographical sketches, obituary notices, and all other purposes for which such information is desired. What has long been needed is an accurate compilation of data, made up of information obtained from official sources, such information then to be carefully edited and classified and kept corrected up to date, for the use and information of licensing bodies, and for any responsible person desiring information for legitimate purposes.

While the necessity for such classified information has been long recognized, until recently conditions have not been favorable for its establishment and maintenance. Now with organization more or less completed, such is possible.

. . . . .  
The American Medical Directory will

differ from directories heretofore issued in three particulars: First, it will be a directory of the American medical profession published and owned by physicians themselves. Second, information regarding college and year of graduation and date of licensure will be verified from official sources. Third, it will furnish the same information regarding each physician, whether he be a subscriber to the directory or not. No paid-for information will be included. It will also combine in one volume the purpose of a general medical directory, as well as a medical society blue book, since the names of all members in good standing of the constituent state associations and their component branches will appear in capital letters as a distinctive mark of such membership. Information contained in the directory regarding each physician will include name in full, year of birth, college and year of graduation, office address and office hours.

The assistance and co-operation of all physicians, and especially all members of the organized profession, is earnestly requested in carrying on and developing this work. The greatest service that any physician can render at the present time is to furnish, promptly and accurately, information regarding himself. For the purpose of obtaining this information a blank has appeared in successive numbers of *The Journal* for the last six weeks. About 20,000 of these have been filled out and sent in.

A number of physicians have written saying: "You will find full information regarding me in the ——— Directory." As practically all directories are copyrighted works, it will be readily seen that such information is not available for the purposes desired. Other physicians have replied, saying, "You will find my complete record in the Transactions of the ——— Medical Society for the year ———." A moment's reflection will show the difficulty in tracing up the personal record in this way. The time required for a physician to fill out and return these blanks is infinitesimal; the time required for the directory office force to trace each individual is great. If each reader of *The Journal* will furnish at once, without further sollicita-

tion, the personal information regarding himself, the work of accumulating the data will be greatly simplified. On advertising page 32 of this issue will be found the information blank desired. All readers of *The Journal* who have not already done so, are urged to furnish this information at once."

It is needless to comment upon the value which such a publication will possess for every member of the profession, and we earnestly hope that all physicians will comply promptly with the urgent request of *The Journal*, and aid in the completion of this important work.

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### THE COUNCILORS' BULLETIN.

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We have before us the first number of *The Councilors' Bulletin*. The suggestion of this publication was made last spring and was adopted "by a practically unanimous vote." It will appear bi-monthly from September to May of each year, and is intended to serve as a medium for the interchange of opinion upon questions pertaining to the work of organization and for the discussion of all matters relating thereto. The organization of the medical profession which is occupying our attention so largely to-day, means the fusion of a vast number of heterogeneous elements into one homogeneous body; it means a unification of purpose and of action which will make the medical profession a mighty power; it means the development of a tremendous force by turning into a single channel a number of small streams whose sluggish currents are singly ineffective. It is a slow work, but one that is worth the time and the labor expended in bringing it to pass. Upon the officers of the State and county associations, especially upon the councilors, falls the burden of the work, and this little publication is intended to aid them by affording the opportunity of discussing the difficulties and the problems they may severally meet with, and of interchanging words of cheer. It will unquestionably be of the greatest benefit to all who will avail themselves of it, and we commend it most heartily.

### A GOOD APPOINTMENT.

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It gives us pleasure to announce that the Committee on Medical Legislation of the American Medical Association has appointed Dr. O. B. Mayer, of Newberry, a member of the National Legislative Council.

Dr. Mayer is a hard worker and has filled many offices in our Association, and at various times has demonstrated his fitness for such an important position. His sound advice and conservative ideas have always been valued and sought in the South Carolina Medical Association. We congratulate not only Dr. Mayer but the American Medical Association.

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### ORIGINAL ARTICLES.

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#### THE SECRET NOSTRUM EVIL.\*

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FRANK BILLINGS, M. D., CHICAGO.

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I shall make no apology for bringing this subject before this section. Its importance to the profession of medicine and to the public justifies an exposition of the evil now. In no other country has this menace to the welfare of the people and to the best interests of scientific medicine developed as it has with us.

Probably the reason is that other countries, with one or two exceptions, protect the people against frauds in foods, medicines, etc.

Some day it is to be hoped that the Congress of the United States will enact a national pure food law which shall include the regulation of the copyrighting and exploitation of proprietary and other medicines.

Just here it will be well to say that the term "proprietary medicine" does not necessarily stamp a preparation or remedy as a nostrum. Webster says that a nostrum is "a medicine, the ingredients of which are kept secret for the purpose of restricting the profits of sale to the in-

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\*Read in the Section on Practice of Medicine of the American Medical Association, at the Fifty-sixth Annual Session, July, 1905.



ventor or proprietor; a quack medicine." Some proprietary medicines are patented, or better, the process of manufacturing an article is patented. This patent protects the discoverer, or owner, in the manufacture of the medicine or drug for a period of 17 years. These preparations are ethical, in that they are not secret, for any one for a small fee may obtain from the patent office of the government a copy of the description of the process of manufacture and the actual chemical composition of any such patented drug or remedy. The chief harm which has come to us in America from the protection by patent of the process of making a chemical or drug has been the resulting high price of the product. Many of the synthetic chemical drugs, like antipyrin, phenacetin, etc., cost ten times their worth as compared with the price of the same drugs in Germany and in other countries. As stated, however, such really patented preparations are not secret; the composition is known. Some of them are of value therapeutically. Many of them are valueless. Some of them are harmful. Most of them we could easily get on without and fare better with the older, more simple remedies. Too many "made in Germany" specifics are shoved under our noses.

Now, as to the other proprietary medicines. All the so-called "patent medicines" put on the market for the public, and many of the preparations exploited to physicians and distributed by them to the public, are not patented, but are protected by a copyright or trade mark. Technically there is no difference between the secret proprietary medicines manufactured for physicians' use and the "patent medicines" exploited to the public. Both are protected by a copyright or trademark name. Both are protected for an indefinite time. They are mixtures, as a rule, of several ingredients.

The relation of the physician to these preparations, however, is very different. Those "patent medicines" which are advertised to the public are not considered ethical and physicians abhor them and rightly condemn their use because they

are often dangerous and always irrational as remedies. On the other hand, the manufacturers of those copyrighted proprietary medicines which are exploited to physicians by extravagant claims of specific therapeutic action, use the doctor as the middle man to distribute the cure-alls to the public.

Medicines so prepared that the busy physicians could easily dispense them found a certain class of doctors eager to use them. The indications for use appeared on the label or in the accompanying literature. Tonics, blood and tissue builders, emenagogues, pain relievers, febrifuges, laxatives, calculi dissolvers, soporifics, bile promoters, heart tonics, cures for Bright's disease, etc., have appeared in countless number and some remedies offered are confidently presented as cures for not one, but a half dozen diseases or symptoms complex. Indeed, the claims of many of the promoters of this class of remedies do not differ in extravagance from the cure-all patent medicines offered directly to the public.

It has been easy to obtain testimonials of the alleged value of many of these remedies. Many even of the "faculty" have extolled them. Why, therefore, should not the less experienced physician use these "elegant," palatable, all-ready to use, with label-specifying-dose, disease-indicating remedies? Prominent physicians and the "faculty" had testimonials in the circulars sent with the samples indicating the virtues; why, therefore, use the simple proved remedies of the pharmacopeia, and especially as the latter would often necessitate the trouble of writing a real prescription.

To the rational physician most of the mixtures, even with the formulæ, are objectionable. Disease is never quite the same in different individuals, nor does the picture remain the same from day to day. The treatment must be modified to meet the varying problem of the morbid process. Rational therapy calls for simple prescriptions; but if there be an objection to mixtures with fixed and known formulæ, what must one say of mixtures of secret or semi-secret composition?

As Dr. Horation C. Wood, Jr.<sup>1</sup> says:

A much more elusive and therefore dangerous evil lurks in the class of mixtures which attempt to cloak their secrecy with a deceptive show of frankness. I think you will grant that the physician is rarely justified in the use of remedies concerning which he has no knowledge, and I maintain that the publication by a drug firm, of whose integrity the physician is absolutely ignorant, of a professed list of ingredients of some mixture is not sufficient knowledge to pardon or to warrant the uses of that remedy. In the first place, if the published formula be correct, it is not enough to know simply the composition of a mixture, the exact quantities must also be known; there is a vast difference between the effects of 1 grain and of 100 grains of opium. Moreover, there is no means of knowing that the formula is a true one, for many of these corporations do not hesitate to pervert the truth.

Many of the promoters of these preparations claim, as chemists or as pharmacists, to be the discoverers of the wonderful remedies and the alleged unusual knowledge of chemistry or of skill in pharmacy has enabled the discoverer to develop in a mixture heretofore unknown, therapeutic qualities. Truth to tell, however, it is known that the proprietors are not always the manufacturers of the preparations they exploit and distribute. Many of the proprietary preparations are made by the large manufacturing pharmacists for the owners. Pharmaceutical skill is doubtless used in these instances, but it is the kind of skill which is for sale and is not personal.

I am informed that it is not unusual for one manufacturer of proprietary mixtures to have several so-called "companies," through which he can more easily exploit and distribute his products.

There is said to be a direct relation between the Dad Chemical Co., the Od Chemical Co., the Sultan Drug Co., the Rio Chemical Co., and the Peacock Chemical Co., or at least that they are linked together through one individual, and that Battle & Co. and the Lambert Pharmacal Co. are related to the above list. It is said, too, that the Vass Chemical Co., the Lotos Chemical Co., and the Valley Chemical Co. are one combination. Doubtless other combinations exist.

Curiosity recently prompted me to look through a number of medical journals and I cannot resist the temptation to quote some of the preparations advertised in them: Aletris cordial, celerina, neurilla, respiton, san metto, Cactina pellets, seng, chionia, thialion, zarcol, ecthol, Hagee's cordial of cod liver oil compound, mandragorine tablets, rheunagon, ponca compound, ammophenin, chloro-bromon, anasarcin, bronchiline, zematol, zymotidine, sulphogen, labordine, satyria, manola, cacodol, eusoma, leprosen, sulphonaphthol, pasavena, neurosine, germiletum, Bonn's passiflora tablets, dioviurnia, tongaline, lithiated hydrangea, melanchol, gonoseptone, calicolo, solsul, saliodin, and so on *ad infinitum*. These are only a few samples of what the physicians of the United States are asked to prescribe. But there are hundreds of secret preparations that are not advertised in medical journals, whose literature and samples come to us through the mails, etc. In the majority of cases, we do not know their contents, and in many instances an analysis shows that they are simply mixtures. Often a prescription written by a physician for a particular case is purloined, put up under a trade-name and exploited as a cure-all.

As an illustration see the official announcement of the Council on Pharmacy and Chemistry regarding certain nostrums that have been exploited as synthetic chemical preparations guaranteed to cure everything. I have no doubt that the majority of the physicians who have been prescribing phenalgin, antikamnia, sal-codeia (Bell), and ammonol were shocked when they found out that, according to the analyses, they had been giving a simple mixture of acetanilid, with bicarbonate or salicylate of sodium or carbonate of ammonium, with a little caffeine in some instances. What physician will be foolish enough to use these preparations, when he can get the same of his druggist for at most one-tenth the cost, but especially what physician with a particle of medical knowledge would think of giving acetanilid if he knew it, in the majority of the conditions in which,

1. "Proprietary Therapeutics," The Journal A. M. A., June 10, 1905, p. 1836.



according to the advertisers, these nostrums are indicated?

What physician would prescribe Gray's glycerin tonie, if he knew that its chief ingredients are gentian, dandelion, glycerine and sherry wine?<sup>2</sup> Could he not write a prescription as good and feel that he was his own judge of what constitutes a tonic?

Let me quote from *The Journal A. M. A.*<sup>3</sup> This, I am told, refers to an article advertised as a cod liver oil preparation—one of the tasteless kind, that has been investigated by a subcommittee of the Council:

We have recently had occasion to open a package of a well-known "Tasteless Cod Liver Oil" preparation. The circular which was wrapped about the bottle was replete with interesting information, especially for the patient, who obtains the remedy in the original package, as prescribed by his physician. He finds in it a list of the diseases in which the preparation does wonders—they range from the dread consumption to cystitis and hemorrhage of the kidney. Most interesting to us, however, is the statement that this compound "contains all the necessary elements of nutrition." It is too bad to disturb this beautiful vision by the report of the chemist. This shows that the product is quite free from oil or proteids; the only nutrient ingredients are alcohol, sugar, and perhaps glycerin. But the claims of the manufacturers are probably correct, for it contains carbon, hydrogen, oxygen, and probably a trace of nitrogen—so does gun-powder.

Perhaps it will now be the turn of strychnin to be advertised as the ideal food. It seems superfluous to point out the moral of this tale.

It is not necessary to enter into a discussion as to whether we should ever prescribe secret proprietary medicines, for in the minds of intelligent men, even with only a smattering of medical knowledge, there can be but one answer. A physician who has a true appreciation of his responsibilities, who has even ordinary knowledge of the action of drugs, and the danger from their unintelligent use, would not think of prescribing for the sick, who have placed themselves under his care, a preparation about which he knows nothing except what the manufacturer, about

whom he knows less, had told him. While there is no excuse for prescribing these medicines, too, many unthinking physicians are influenced to do so by the claptrap designated "literature," which the exploiters publish about their preparations.

There is not a secret proprietary preparation that has any more value, from a pharmaceutical or therapeutic standpoint, than has the ordinary prescription of the average general practitioner. Stop advertising them and they would be forgotten, just as "patent medicines" pass away if they are not advertised. A hark back 10 or 15 years will call to mind many concoctions which physicians were asked to prescribe, and which, according to the advertisements, performed wonders, but now are heard of no more. Their advertising literature stopped coming and the nostrum-prescribing doctor ceased to use them.

What is the cause of the nostrum evil? There are several.

1. Pharmacology and therapeutics are neglected relatively by many of our medical schools. Anatomy, physiology, pathology, diagnosis, etc., are emphasized and too often the usefulness and limitations of drugs are neglected. Too frequently drug nihilism is taught. If the student were fully taught the physiologic action of drugs, the art of prescribing, preferably single remedies or in simple combination, using if he desires the pharmacopeial preparations prepared by reliable manufacturing pharmacists, and at the same time if he were taught when not to rely on drugs, but frankly to prescribe for his patient a course of hygienic measures which alone would accomplish all that would be required, he would not be the willing dupe of the nostrum vendor, as he now is.

2. The reputable manufacturing pharmacists deserve great credit for the improvement they have made in pharmaceutical products. They have afforded us official preparations in the form of pills, tablets, syrups, tinctures, extracts, etc., which are elegant in appearance, often palatable and usually potent.

2. "Each half ounce is stated to contain dilute phosphoric acid, 12 minims; gentian root, 10 grains; extract of taraxacum, 15 grains; glycerin, 80 minims; sherry wine, 80 minims; carminatives, q. s."—"Thesaurus of Proprietary Remedies," p. 148.

3. June 17, 1905, p. 1943.

For this advance in pharmacy, a distinct credit to our country, we owe them our thanks.

Unfortunately, many of them have not stopped at this point, but have manufactured their own special mixtures which are just as objectionable as the products of the special manufacturers. They, too, have been active with their agents in visiting physicians and in distributing "literature." This encourages drug-giving in specific mixtures for special symptoms, and is wrong. With one hand they do good work, with the other much evil is done.

3. The nostrum makers at first copied the methods of the reliable manufacturing chemists, in exploiting their products, but they have gone a step further and have reached a point where one may say that they have subsidized the medical press. I know I am on dangerous ground when I make this statement, but right here is the chief cause—and the remedy. How many of our so-called medical journals are subsidized by medicine manufacturers I do not know, but all physicians know as well as I that there are many, and I do not refer to the so-called house organs. I unhesitatingly affirm that one-half of the medical journals of the country would be out of existence if it were not for the nostrum advertisements. Under the circumstances, therefore, can we expect these journals to say anything? Need we be surprised that scarcely a journal published the official report regarding the acetanilid mixtures, when the preparations hit were the best paying advertisements in the country?

What is the remedy? Publicity. The enlightenment of the profession. The truth regarding not only what the preparations contain, but who makes them. Certainly no honest manufacturer will object to this last proposition, and no honest physician will put up with less than the former.

The Council on Pharmacy and Chemistry has been created to investigate the non-official preparations, to find out the truth about them, and to publish its findings. It is not necessary to repeat here

the results of the work already done by this body. All physicians have read, or may read all about it. In my opinion there has been no movement undertaken by the American Medical Association that will be so far reaching as this one to rid us of the blight of the nostrum evil. For the first time, we see the possibility of the elimination of a part, at least, of this curse to American medicine. It is the first practical solution offered of a most difficult problem.

But—and I want to emphasize what I am about to say—the movement will have the most determined opposition that money can bring. Millions are being made annually by the nostrum manufacturers, and they will not sit idly by and see this wealth-producing business done away with if they can prevent it. It won't be an open fight, for their business will not stand publicity. They will have with them those so-called medical journals which are published solely in their interests.

This movement will have the sympathy of every thinking physician of the country, but sympathy does not win battles. In this fight those who are representing us should have all the support we can give. In society meetings especially we should aid in the propaganda by helping to enlighten and to interest those of our profession who have given the matter no thought. We should support those journals that represent us, and not tolerate in our offices those that we know to be subsidized and to represent their advertisers rather than their readers.

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#### FACTS FAVORING EARLY REMOVAL OF FIBROMYOMATA OF THE UTERUS.

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LINDSEY PETERS, M. D.,  
COLUMBIA, S. C.

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Owing to the recent recognition of certain pernicious effects of myomata of the uterus which were hitherto either overlooked or not attributed to the tumors, these growths have come to be regarded as veritable "wolves in sheep's clothing."



We were formerly taught to treat these tumors as usually innocent, harmless growths, and few, if any, operators deemed it justifiable to remove them unless they caused suffering or ill health; now, on the contrary, we find many of the ablest surgeons of Europe, Great Britain and America advocating their removal as soon as they are discovered. This is a very decided change of attitude, and it is of interest to note how it has been brought about. This radical view is based upon the dangers incident to degenerations of the tumors, upon the dangers of complications which may be fatal or cause suffering and disability, and upon the danger of fatal change in the heart and blood-vessels produced by the growths in the uterus. That these dangers are real and not imaginary appears evident from a review of the published investigations on the subject.

As well as I can ascertain from the literature at my command, the first to advise the early removal of myomata, whether they were giving trouble or not, was C. P. Noble, of Philadelphia. He took this stand in 1901 as the result of an analysis of 218 cases of fibromyoma in which their various complications and degenerations were particularly noted, as well as the mortality and morbidity in that series of cases. In this interesting paper Noble laid emphasis upon the great frequency of degenerations and various complications of these tumors which caused death or invalidism; he also called attention to the frequency of the association of phlebitis and embolism with fibroid tumors. In controverting the classical teaching that myomata may be expected to atrophy and disappear after the menopause, Noble said: "No instance of a fibroid tumor having disappeared after the menopause has come under my notice. \* \* \* \* \* That one, having large opportunities for observation, could have had this experience indicates that the disappearance of fibroid tumors as a result of the menopause or as a result of pregnancy is not to be expected."

In addition to the series published by

Noble, Cullingworth has investigated a series of 100 cases, Mary Scharlieb 100 cases, Frederick 125 cases, Hunner 100 consecutive cases occurring in Dr. Kelly's service, McDonald 280 cases and Webster 210 cases.

Another important observation of Noble's, which has been confirmed by the subsequently reported series of cases, is that in uterine myoma cancer of the body of the uterus occurs more frequently than cancer of the cervix, whereas the occurrence of cancer in the uterus regardless of the presence or absence of myomata is 3 or 4 times more frequent in the cervix than in the body. From the combined statistics of the observers mentioned above, including 1,398 cases of uterine fibroids, cancer of the body occurred 32 times and cancer of the cervix 13 times. In other words, cancer of the body occurred  $2\frac{1}{2}$  times as often as cancer of the cervix, whereas its usual frequency is about  $\frac{1}{4}$  that of cancer of the cervix. This remarkable increase in the frequency of occurrence of cancer of the body of the uterus in cases of fibromyomata seems to show that fibroids are clearly culpable of producing cancer of the uterus.

Sarcomatous degeneration of fibromyomata has been noted for many years and statistics of large numbers of cases show that the frequency of its occurrence is  $1\frac{1}{2}$  to 2 per cent. Cancer is estimated to occur in 3 to 5 per cent. of cases of fibromyoma, making a total of  $4\frac{1}{2}$  to 7 per cent. of malignant degenerations. This alone is a powerful argument against procrastination in dealing with fibroids.

Another important contribution to the study of myomata was made in 1902, when Kessler, a German, examined not only the gross specimen, but also microscopic sections from the heart in a case of sudden death from heart failure on the 7th day after removal of a 56-pound myoma. He found marked hypertrophy of both ventricles and both auricles of the heart, due to hyperplasia of the interstitial and interfascicular fibrous tissue. He noted also atrophy of the heart muscle

fibres. He attributed these changes in the heart tissues to the resistance to the circulation produced by the enormous tumor.

It has been known for a long time that the heart is frequently degenerated in women with uterine fibroids, but this observation by Kessler is the first accurate knowledge we have gained as to the exact nature of the heart changes. Fleck, another German, in 325 cases of uterine myoma found an associated heart lesion in 133 (40.9%). A series of 71 myoma cases at the Berlin Charité, reported in 1894, showed heart lesions in 40.8%.

Paulli, in reporting a case of fibromyoma of the uterus with thrombophlebitis occurring alternately in the legs and arms, in a woman of 46 years, expressed the opinion that a developing myoma is not merely a local affection, but that the organism suffers generally, possibly with a tendency to a triad of symptoms, like the triad in exophthalmic goitre, in Addison's and in Bright's disease. The triad with myoma is the tumor in the uterus, a series of nervous symptoms—neurasthenic, neuralgic or mental—and a general vascular disturbance entailing a tendency to thrombophlebitis. In 83 operations for myoma at the hospital in Paulli's charge 3 deaths from embolism of the pulmonary artery occurred (3.6%). In 362 abdominal sections embolism of the pulmonary artery was observed only in these 3 myoma cases. Rosthorn had 1 death from embolism in 66 operations for myoma; Michel, 2 in 586; Buckhardt, 7 in 236; Hofmeier, 3 from embolism and 1 from "heart stroke" in 233 abdominal sections for myoma and Czempin 2 in 82, but Engstrom had no deaths from this cause in 100 operations.

Baldy, of Philadelphia, reports 366 cases of fibroid disease of the uterus in which sudden death from pulmonary thrombosis, "heart-stroke" or cerebral apoplexy occurred 19 times (3.55% of the cases). He says the attacks occurred "as suddenly as a stroke of lightning," \* \* \* \* \* "Without warning or apparent cause in any case—one patient was stricken while laughing and joking with other patients and was dead almost

as soon as the nurse could reach her; another patient was aroused suddenly in the night from a sound sleep, sat up in bed, gasped and dropped over dead." Baldy had another patient from the Polyclinic Hospital who had been home for two weeks and while talking and laughing with friends sat down on the bed, fell over and died before help could be summoned.

These investigations teach us that myomata of the uterus are not only, as we have long known, subject to various degenerations or complications which produce invalidism or death, but that they are associated with a fatal heart lesion or thrombophlebitis in about 3 to 5% of the cases.

All physicians are familiar with the great frequency with which these tumors occur and hence it is clear that thousands of wives and mothers and sisters are invalidated or lost yearly from the above causes, who could have been spared by early removal of the growths. I think it will be generally agreed that the fatal or disabling effects of myomata are rarely produced while the tumors are young and quite small; certain it is that their removal in the early stages of their development is easy and attended with an almost insignificant mortality. Moreover, when the growths are small they are far less likely to have associated disease of the tubes and ovaries and can be removed without the sacrifice of these structures or of the uterus. The conservative attitude, therefore, is the one which favors the removal of these tumors before they attain a great size undergo destructive degenerative changes, cause complications which impair health and render operation hazardous or before the heart and blood-vessels become involved in a possible generalized fibromatosis. I would not advise operation for the removal of very small myomata unless they were giving trouble, but the logical position to take, in view of the dangers cited above, is to strongly advise their removal without delay when they become large, even without symptoms, or when they begin to cause pain.



menorrhagia, metrorrhagia or other symptoms, no matter what their size.

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#### THE WEARING OF GLASSES.

S. H. GRIFFITH, M. D.,  
 GAFFNEY, S. C.

A very general belief is prevalent in the minds of the laity that when a person once begins wearing glasses he is thereby forever afterward incapacitated for the same degree of vision without them, as he enjoyed before resorting to their use. And so a great many people go stumbling through the world resolutely denying themselves good, sharp, comfortable sight with the idea of escaping this imaginary penalty. That the penalty has no real foundation in fact, but is simply a product of the imagination—a delusion arising perhaps from comparison of the natural defective sight with the perfect vision obtained by use of the glasses, the former suffering merely by contrast—is evident to every one who understands the physiology of the human eye and the principles of optics involved. Every oculist knows that glasses, by correcting errors of refraction and thus relieving the strain formerly necessary to see clearly and distinctly, retard the advance of the trouble,

and yet this notion has gained such deep root in the minds of the people that the opinion of the most learned and scientific oculists of the day often fails to eradicate it.

Mrs "A" tells Mrs. "B" that it is a fact. Dr. "C" labors under the suspicion of wanting to sell a pair of glasses and so the combined knowledge and experience of the whole optical fraternity is discounted one hundred per cent. Of course, we must assume that the glasses have been properly fitted, for on this everything depends.

The eyes of children and especially of school children are allowed to suffer more than, perhaps, any other class of people on account of this groundless prejudice against their wearing glasses. Many a child has been considered a dunce at school when he simply failed to see what was placed before him. Very often the child himself doesn't know what the trouble is—doesn't realize that his eyes are at fault, and the teacher not knowing that refractive errors are common in childhood stupidly mistakes a lack of vision for a lack of brains.

It is a law to which there are no exceptions that every object to be distinctly seen must be focused at an angle not exceeding five minutes on the retina of the eye—and to accomplish this is the whole object of glasses. The normal eye will focus rays of light passing through its lens at this angle and no artificial help is needed. In myopic (nearsighted) and in hypermetropic (farsighted) eyes, if the degree of error is small and the person young and vigorous, sharp sight may still be had for a time by virtue of that wonderful little mechanism of the lens known as the "accommodation." If this effort is continued, however, or if the degree of error is large nature can no longer accomplish this result without artificial help, and so vision under such circumstances is blurred, indistinct and perhaps painful.

There comes a time in the course of nature when this accommodation begins to decline and is eventually lost—when the lens loses its elasticity and can no

longer accommodate itself to objects both far and near. In this condition we have the presbyopic or "old man's eye."

More complicated than any of the above obstacles to sight and often combined with each is that known as "astigmatism," a very small degree of which is sufficient to produce great discomfort.

To correctly diagnose these refractive and accommodative errors and by the use of suitable lenses make an imperfect eye artificially perfect is a part of the oculist's business—and to do this perfectly and successfully at all times, requires an amount of knowledge, skill and experience little dreamed of by the laity. It may readily be seen that without a thorough knowledge of the varied and often complicated conditions present in each individual case a glass may be prescribed which will not only fail to produce the desired result but may do irreparable injury by increasing the degree of error instead of neutralizing it. A myopic glass placed before a hypermetropic eye can, of course, only increase the hypermetropia and *vice versa*. There being directly opposite conditions such a mistake as the above would seem to be almost impossible and yet they sometimes so nearly simulate each other that a most careful examination by a competent oculist is necessary to diagnose them correctly. The unfortunate victim of such a blunder often persists in wearing his glasses for weeks and months heroically enduring the increased pain and discomfort they cause under the impression that his eyes have not "come to" the glasses—(and they haven't).

The importance of this knowledge on the part of the oculist is great. To the patient its value sometimes equals that of sight, whatever this may be. When we realize that the loss of this faculty would rob us of nine-tenths of everything that makes life worth living we see how nearly it approaches in value that of life itself.

Is it not passing strange then that so many people are willing to trust their eyesight in the hands of any unknown quack who may chance to come along who has a case of test lenses and the prefix "Dr." fraudently attached to his name. The less known about him the better just so he purports to come from a distance. This latter requirement is his very "stock in trade," and is absolutely essential to his success. Oh, what a pull on the mind of the public has this idea of distance! What enchantment does it lend to men! Everything worth knowing, worth seeing, worth having must come from a distance. A man's knowledge, experience and skill are usually rated below par "in his own country and among his own kindred," his proficiency being discounted to the extent that his previous history is known—and so the expert at home must step aside for the humbug from a distance.

There are a few points that I wish to emphasize in conclusion. Don't imagine that your man at home knows nothing just because you know him. Judge him by his natural ability and his opportunities, for becoming proficient and not by the geographical position of his town. Don't think that the inhabitants of large and distant cities have a corner on the brains of the universe. That the countryman is necessarily devoid of the faculty of thinking deeply, correctly and systematically. Reason logically that the man who has devoted his whole life to the study of one particular subject and who has access to the combined knowledge and experience of thousands of others who have done the same, knows more about that subject than you do. And lastly, when rays of light entering your eye are not focussed at an angle of five minutes on the retina, consult the man whom the dictates of reason and common sense would suggest as being most worthy of your confidence. Follow his advice. Believe him to be honest until he is proven dishonest. Don't believe that for the paltry profit on a pair of glasses *he would abuse his conscience and injure your eyesight.*



## THOROUGH ORGANIZATION A NECESSITY FOR THE MEDICAL PROFESSION.\*

CHAS. W. KOLLOCK, M. D.,  
CHARLESTON, S. C.

There is a custom that is becoming universal in all parts of the country which is known as the celebration of Home Day. On this day those who have left their old homes come back, and their return is fittingly celebrated by themselves and those who have remained at home. Such reunions must be productive of good, for what can be more pleasant than to meet again the friends of long ago and renew the ties that have been broken by the lapse of time. 'Tis true that time will have made sad changes, and the faces of many dear ones will be missed, but for all that it does a man good to go home again and prove to himself, and his old friends that he has not forgotten where he was born. This is not a home day but to me it is coming home again—home to the Pee-Dee country where I first saw the light and where my boyhood days were spent—home to the Pee-Dee country, where my people settled more than a century and a half ago—home to the Pee-Dee country, where most of my dear ones are sleeping their last sleep in the graveyard of old St. David's, hard by where the turbid waters of the grand old river continue their ceaseless flow; home to the Pee-Dee country, where live the sturdiest men and prettiest women—a veritable God's country, with a history of which every man and woman should be justly proud.

Is it strange then, that I am glad to come home and am always proud to say that I am from the Pee-Dee? When your president wrote and invited me to read a paper before this Association, for which I have the greatest veneration and respect, I replied immediately that I would, and was truly proud of the honor he had conferred upon me. I should like to talk about everything and to everybody in the Pee-Dee country, and I assure you that

my heart swells with honest pride when I read and hear of the many advances which you have and are making in every profession and branch of industry, but I am here to speak of but one phase of the mighty subject of medicine, which naturally is of paramount interest to us as physicians.

Already the science of medicine has gone far beyond what the most vivid imagination of the most sanguine disciple of Hippocrates could picture, and the world even now astounded at its progress and discoveries is waiting with eager expectation for the next wonderful step towards alleviating human suffering. An example of the marvellous work of the profession is the discovery of the mode of transmission, controlling and practically stamping out the dread disease that for so many years has ravaged our South Atlantic and Gulf ports; which caused the people to become panic stricken, to flee from their homes and remain away for months at a time, and which paralyzed business to such an extent as to cause at times actual suffering for the necessities of life. By this control of yellow fever not only has there been a great saving of human life and protection of business interests, but another most important lesson has been learned, which is, that this most wonderful feat was accomplished only by the most thorough organization in every detail of the work. The professional, national, State and civil authorities, ably seconded by educated and intelligent laymen, have worked together as they never worked before, and now the fruits of their labors are before them. No panic, no great interference with business, no wide spread of the disease and fewer deaths than have ever occurred in any previous epidemic, this stupendous work has been dominated by members of the medical profession. It is upon this subject of organization that I wish to talk, for with such a lesson before us it does not seem hard to apply it to our own cause—to the family—as it were, for organization, thorough organization, is the one thing most sadly needed by the medical profession. With its thousands of members, it should wield an influence second

\*Read before the Pee-Dee Medical Association, Nov. 15, 1905.

to none in this great country, but has it done so in the past, has it had any potent voice in the National or State Government, and has it made its influence felt in any important question until recently? By its organization, by its willingness to co-operate with any who might assist the profession was in a position to say to the National and State Government, and to the people, we can stamp out this epidemic of yellow fever if you will give us money and your intelligent assistance. Both were readily and freely given and we see the result. The profession has done work which the educated layman can understand and has proved it by results which it shows to all who care to see.

Education, therefore, is the first requisite for organization, and without it no organization can ever be complete nor powerful. It is the key note of the whole affair, let every man have a solid foundation of education and then let him do what he pleases. I care not whether he be a wood-chopper, a farmer, a lawyer, a doctor, or what, he will outstrip his fellow worker who is uneducated. In the medical profession education is especially necessary, not medical education alone, but a good, solid foundation of general knowledge, for that of medicine to rest upon. Therefore, fellow members, let us get together first on the educational subject, let us begin by improving ourselves in every possible way, and especially by seeing the work of others, for when a man thinks he cannot learn from others, then he is in most danger of falling behind in the race. Let us organize and see to it that those who intend to study medicine shall be prepared to do so. There is no reason why a man should not step from behind the plow to the lecture room, if he is prepared. Thorough organization will compel college authorities to require that applicants for admission shall be prepared to take up the study of medicine and, just here, reform is needed in some of our colleges. So great is the competition among them for students that they admit practically anyone who applies, without having any knowledge of his fitness for the work. I was informed last year by a professor of one of the largest

and foremost medical schools that their applicants were, with few exceptions, all college graduates, and if not they were required to stand an entrance examination which, if they passed successfully, proved that they were upon equal footing with those who had received degrees. As yet all colleges do not have this requirement, and the result is that many men are annually graduated who, not being educated themselves, see no reason to require it of others, and therefore oppose all efforts which tend to elevate the standards. They realize that they are out-classed when thrown with those who have been better educated and naturally do not wish the standards raised. We must organize and either prove to these men that they are wrong or else leave them behind. But we can by perseverance and patience prove to them that we are right, and the man who can rise above himself, see his own shortcomings and try to improve himself and help others, will not only be a good member of the profession, but of necessity a good organizer.

Disorganization, or lack of organization, has been the most serious drawback and obstacle to the advancement of the medical profession in this State, and consequently we are about twenty years behind where we should be. Efforts to enforce more thorough education have been balked again and again, and in most instances the obstacles were placed by those who lacked thorough training, who did not wish it, and their efforts were successful because there was a general lack of organization in the profession throughout the State, and it practically ended in laymen (in many cases themselves uneducated) deciding what it was necessary that a physician should do and know in order to practice his profession. Not only should we organize to educate men for the profession, but we should also educate the laity as to the necessity and importance of having thoroughly educated physicians to attend them. In this respect there is a woeful lack of organization and education, as is constantly to be seen by the laity, (even the intelligent,) employing irregulars, charlatans and quacks in preference to the regular physicians. For



this the profession is chiefly to blame from lack of organization caused by lack of education. Sometimes these irregulars outshine the regulars so far that it is not strange that they should be chosen. The laymen must be educated and the doors should be thrown open to him that he may see our practice is common sense, practical and withal scientific.

Educate him in medical subjects of general interest to all and prove to him that we are working for the good of mankind, that there is nothing mysterious in the practice of medicine, but that everything is based upon scientific principles which can be understood by any one who applies himself to its study. An example of the good to be obtained from educating laymen upon medical subjects, which should be more or less familiar to all, is the wonderful progress which has been made in preventing infection by and treating tuberculosis. Since he has learned more of this dread disease he has co-operated with the physician in fighting it by giving freely of his money for the purpose of investigation, treatment and prevention. The lack of concerted action on the part of medical men is proverbial and has often caused the laity to lose confidence in them as a body, to say that doctors never agree and to even ridicule their practice and efforts to bring about needed reforms. I repeat that want of organization has been and is the cause of this lack of confidence, and far too often we see members of the profession taking sides with the layman against the profession. How often have we tried to have some important medical measure passed by the legislators of this State, and have seen it defeated by the influence of some political medical member or by physicians who were not members, simply because they had not been consulted. With thorough organization this could not happen, for then any measures presented by the profession would have the unqualified support of every physician in the State, and with such support it would be a brave politician who would dare to oppose it. Organization is again needed for the promotion of health

by the prevention of disease. Do you think that if the profession was well organized that the epidemic of smallpox which has been prevalent in this State for several years would not long ago have been stamped out? Would the Legislature have dared to refuse the appropriation which was requested by the State board of health, and to have expressed openly their opinions that the disease was not smallpox, if the profession was organized? With such co-operation as we have seen in New Orleans during the last few months there would not have been a case of smallpox in this State for the past two years, unless brought from without its bounds. Again, the fault lies mainly with the profession; lack of education, jealousy and politics have caused distrust among the members and the laymen have been quick to see this weak point and attack it. I repeat, gentlemen, that for such an epidemic to have lasted so long in a State where immigration has been small is a disgrace from which we shall not soon recover, and proves us to be twenty years behind the times. Organization, therefore, is necessary to bring to the profession the respect and confidence which it deserves from the people, but without education such organization can never be effected.

Organization is necessary to purge lists of numerous dead-heads and dead-beats. There are thousands of people in this country who are well able to pay a physician for his work, but who systematically scheme to escape, and successfully do so. Organization would soon show these "grafters" that times have changed and make them pay for what they receive.

Again, gentlemen, we must organize to promote better feeling among the members of the profession. It is well to purge our lists of those who are dishonest and debased in any way, but first let us try a little missionary work in our ranks—get the motes out of our own eyes and then try for the offending beams in the eyes of our brothers. A little kindness and patience administered in oft-repeated doses will accomplish more than strict laws and harsh expressions. Convince a man that

he is on the wrong track and he will often become an ardent co-worker in the cause, but when arguments have failed and kindness repulsed, then let the organization be so thorough that the offender shall be unanimously cast out where he will be like an owl in the wilderness and a pelican in the desert. By such organization he will not only be dropped by the profession, but ostracised and distrusted by the laity, and his ruin will be complete.

The work must begin in our homes, with our children, by educating them as thoroughly as our means will allow. Inculcate them with a respect for the medical profession and its members. Teach the students in our offices as much medicine as possible, but help them also to realize not only the professional, but other responsibilities which they must incur on account of the high standard of the profession of which they hope to be members. Let our colleges devote a portion of their time to teaching students the responsibilities of their positions, not only as medical, but as men occupying positions of trust and importance in the communities. Teach them the importance of working together for the profession and its advancement, the importance of organizations in their midst and of frequent meetings, for reading papers and discussing medical subjects, the importance of being keenly alive to everything pertaining to the prevention of disease and sanitary improvement. Personal differences must be overlooked, forgotten or in some way amicably adjusted so that on the rolls of the county societies shall appear the name of every regular physician of the county, and in the councilor district every county shall be fully represented. Then will the State Association be what it should be—fully representative of the profession—and a body which every layman must respect and whose opinion on matters of medicine will be final.

Let it not be understood that I would make the profession a great medical trust which would exclude good men from its ranks, become a tyrannical power in the Government and oppress the poor and deserving; on the contrary, I would have it

an organization that could be trusted implicitly by everyone; an organization that would extend a welcoming hand to all who were deserving and prepared to enter its ranks; an organization upon which the Government could depend absolutely and from which it could and would always seek counsel in matters pertaining to health and sanitation; an organization whose highest aim would be to stamp out disease and to alleviate the suffering of mankind, and an organization which would demand that its members should be educated, clean and honest.

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### GALL STONES.

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LE GRAND GUERRY, M. D.,  
COLUMBIA, S. C.

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Mr. President and Gentlemen of the York County Medical Society: I must first express to you my sincere appreciation of the compliment you have conferred on me by asking that I should read a paper before your society, at this its August meeting.

It is a great pleasure as well as a privilege for me to be with you to-day, and I trust that some good may be gained thereby. In casting around for some suitable subject of practical importance on which to write, it has occurred to me that none could be more practical, or more important than Gall-Stones.

Statistics compiled from the highest authorities on this subject prove that gall-stones are present in about ten per cent. of all bodies that come to the post-mortem table for examination. One high authority makes this statement, "On an average every tenth human being, and of elderly women perhaps one-fourth, has gall-stones." As an explanation of the remarkable frequency of this malady is submitted the following: The gall bladder bears a close resemblance in construction to the appendix, urinary-bladder, and renal pelvis. We have at one end of each of these organs practically a closed pouch, and so long as no trouble arises to prevent them from



emptying themselves all is well, but just as soon as some obstruction arises trouble is very likely to follow. "The injury may be simple catarrhal at first, but will later become destructive to the mucous membranes, giving rise to ulceration; this will result in cicatricial contraction, then in further obstruction." Manifestly in an organ so placed and so constructed, drainage is imperfect, which increases the likelihood of infection; we now know that infection nearly always precedes the stone formation. On examination into the history of any considerable number of cases we practically always find that the patients have, for a long period of time, suffered from so-called indigestion, gastritis, etc. This is the symptom that needs to be watched most closely, for often by its just and accurate interpretation we will be able to make an early diagnosis, and here as elsewhere the sooner we make our diagnosis the more promptly we afford radical relief and the greater will be our chance of a permanent cure. Conversely, the longer the disease is allowed to stand the more extensive and severe will be the pathological process, and the less likelihood of a cure. Indigestion is not nearly so often a disease, *per-se*, as it is a symptom. There is no more frequent mistake than that of treating those vague gastric disturbances as indigestion: as has been said already, in nearly every instance one gets a history of "chronic gastric disturbance." Curiously enough there is a definite relationship between the muscular contractions of the stomach and the gall-bladder. A slow chronic infection with obstruction to the outflow of bile is the essential factor of gall-stone formation. In six consecutive cases operated on recently, there was definite history of typhoid-fever in each case.

The following table will illustrate fully the etiology of gall-stones:

1. The bacillus coli and the bacillus typhosus are the specific organisms concerned in the formation of cholesterolin calculi.

2. The streptococcus pyogenes and the staphylococcus pyogenes aureus are rarely

the causes of gall-stone formation. When they are, the stone consists solely of calcium salts.

3. If the bacillus coli and the streptococcus or staphylococcus are present, the stone is of mixed formation, consisting of cholesterolin, calcium salts, and bile pigment.

4. The bacillus subtilis grows well in bile but does not alter it in any way.

The following conclusions may be accepted:

1. The chief constituents of gall-stones, cholesterolin and bilirubin and calcium, are produced by sub-acute inflammatory changes in the mucous membrane of the gall bladder, which result in desquamation of epithelium and increased production of mucus.

2. The injection of a virulent culture of micro-organism produces an acute cholecystitis without the formations of gall-stones.

3. The injection of attenuated culture causes no change if drainage from the gall-bladder is free.

4. Retention of bile, brought about by the introduction of sterile foreign bodies does not cause the formation of stone.

5. If retention of bile be brought about by ligature of the cystic duct, or by the introduction of foreign bodies (which cause a stasis of the bile adhering to them and between them), and an attenuated culture be injected, stone formation will occur.

6. The gall-bladder is the chief seat of the formation of gall-stones.

7. The clumping of typhoid bacilli within the gall-bladder may possibly furnish an explanation of the occurrence of cholelithiasis after typhoid fever.

Symptoms:

1. Pain.

Pain due to gall-stone formation is either localized or referred; localized pain is caused by increased tension, and is limited to the gall-bladder; in certain cases where the infection is very virulent and more widespread, pain at times is quite unbearable.

"The most characteristic and constant sign of gall-bladder hypersensitiveness is

the inability of the patient to take a full inspiration when the physician's fingers are hooked up deep beneath the right costal arch below the hepatic margin. The diaphragm forces the liver down until the sensitive gall-bladder reaches the examining fingers, when the inspiration suddenly ceases as though it had been shut off. I have never found this sign absent in a case of calculus or in infectious cases of gall-bladder or duct disease."

Both the localized pain and the more diffused pain are due to infection and inflammation; in the one infection is confined to the gall-bladder, producing gross changes, in the other the inflammatory process has involved the adjacent structures and welded them together with dense, unyielding adhesions.- Pain due to gall-stone colic is about as terrible suffering as one is ever called on to bear. This variety of pain is always due to the spasmodic contraction of the muscular layers of the systic or the common duct in their effort to expel a stone; should the stone be small enough to pass through the duct without causing muscular spasm the suffering is not so intense. The spasmodic pain of hepatic colic is not observed so often as the dull or more localized pain of the diffused infection already mentioned; for this reason, in a greater number of cases, the stones remain in the gall-bladder. By referred pain is meant pain that is referred to the right sub-scapular region, occasionally to the left.

#### Nausea and vomiting:

Nausea and vomiting are partly reflex and partly due to direct involvement of the stomach. Moynihan says: "It is the frequency of nausea and vomiting that is responsible for the unjust and heavy burden laid upon the stomach. If one wished to frame an epigram he could with truth say, that the most common symptoms of gall-stones were due to indigestion."

#### Jaundice:

Jaundice is a rare symptom of cholecystitis. According to Murphy it is only present in about fourteen per cent. of all cases, which opinion is in thorough accord with other competent observers.

Jaundice in gall-stone disease depends on the presence of a stone in the hepatic or common ducts. Stones in the cystic duct do not produce jaundice unless they are unusually large. Jaundice due to gall-stones is practically always preceded by colic. One high authority makes this distinction, in jaundice due to gall-stones the golden yellow predominates, in jaundice due to malignant disease the green color. We must remember that in over 80% of cases where jaundice is due to common duct obstruction by gall-stones the gall-bladder will be found contracted; where we have a dilated and distended gall-bladder with jaundice the cause will be other than stones. A painless and deepening jaundice with a distended gall-bladder is very characteristic of malignant disease, most probably at the head of the pancreas.

"There were 187 cases of obstruction of the common duct from all causes. Of these 100 were due to obstruction from causes other than stone, and 87 were due to obstruction by stone. Of 100 cases in which obstruction was due to causes other than stone, in 92 cases there was dilatation of the gall-bladder; in eight cases there was a normal gall-bladder or an atrophy of the gall-bladder. Of 87 cases in which the obstruction was due to stone, in 70 cases the gall-bladder was small and atrophied; in 17 cases the gall-bladder was dilated."

The following is now generally referred to as Courvoisier's law: "In cases of chronic jaundice due to blockage of the common duct, a contraction of the gall-bladder signifies that the obstruction is due to stone; a dilatation of the gall-bladder, that the obstruction is due to causes other than stone."

#### Fever:

The temperature has been aptly styled the "steeple" temperature because the variations are so sudden and varied. Murphy speaks of the "temperature of a cholangic infection." One's temperature will rise to 105 degrees F., then almost as suddenly fall. Often times we have a rigor, especially in the severer cases. Between the paroxysms the temperature may



remain practically normal. The rise and fall is very abrupt and irregular.

#### Tumor:

Tumors of the gall-bladder are generally easy to recognize. Thus may be due to malignant disease of the gall-bladder itself, or to anything that may produce obstruction to the common duct. In not a few instances the stones are so numerous as to produce a tumor. Where tumor is present we usually find the characteristic pear-shaped mass immediately beneath the edge of the liver and under the 9th costal cartilage.

We close our paper with the following grouping of symptoms as being those which will most usually enable us to make an early and accurate diagnosis:

1. Digestive disturbances, a feeling of weight or burning in the vicinity of the stomach after eating; gaseous distention of abdomen.

2. A dull pain extending to the right from the epigastric region around the right side about at a level with the tenth rib, passing to a point near the spine and progressing upwards under the right shoulder blade.

3. A point of tenderness upon pressure between the ninth costal cartilage on the right side and the umbilicus.

4. In many cases there is a slight tinge of yellow in the skin, not sufficient to be recognized as icterus, but still sufficient to be perceptible upon close inspection, especially on the days on which the patient is not feeling very well, when she complains of feeling "bilious."

6. There is usually an increase in the area of liver dulness.

7. There may be a swelling of variable size opposite the end of the ninth rib.

8. When stones obstruct the common or systic duct we have the clay-colored stools.

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#### COUNTY NEWS.

##### Charleston.

On Dec. 11, '05, the annual meeting of the Medical Society of S. C., of Charleston Co., was held. The feature of the evening was the address of the retiring president, Dr. W. Peyre Porcher, whose efforts for the welfare of the society and of the profession at large have been untiring. After the

meeting the members of the society and their guests of the naval and marine services enjoyed a delightful smoker.

The following officers were elected for the ensuing year:

President, Dr. C. M. Rees.  
Vice-president, Dr. John L. Dawson.  
Secretary, Dr. J. Creighton Mitchell.  
Treasurer, Dr. Rowland Alston.

Dr. Wm. Henry Johnson was elected to succeed Dr. C. P. Aimar upon the Board of Censors.

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#### Laurens.

The Laurens County Medical Society held its annual meeting at Laurens on Monday, Nov. 27th, 1905. Dr. Job J. Boozer, president of the Society, presided. There were present for the meeting about twenty physicians.

Two sessions were held in order to have Dr. Mayer of Newberry present at the meeting in the afternoon. The morning session was devoted to general business and the report of cases.

The election of officers for the ensuing year followed, resulting in the selection of the following: Dr. J. H. Miller, president; Dr. W. H. Dial, 1st vice-president; Dr. S. F. Blakely, 2nd vice-president; Dr. A. J. Christopher, treasurer; Dr. Rolfe Hughes, recording secretary; Dr. W. D. Ferguson, Dr. J. H. Teague and Dr. T. L. W. Bailey, standing committee on ethics. Dr. Isadore Schayer and Dr. Bailey will read papers of their own selection at the January meeting.

The afternoon session was given over to the reorganization of the Society by Dr. O. B. Mayer, of Newberry, counselor for this district, and his practical address before the Society. As reorganized the Laurens Medical Society becomes a component part of the State Medical Association.

The out of town physicians present were: Drs. S. F. Blakely of Ora, J. Q. Wilbur and J. L. Fennell of Waterloo, E. W. Pinson, B. Noffz and J. H. Miller of Cross Hill, J. W. Beason of Gray Court, C. D. East of Goldville, E. F. Taylor of Renno, Bailey and Young of Clinton, C. A. Saxon of Huntington.

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#### OBITUARY.

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##### DR. ARTHUR O. BOWMAN.

Dr. Arthur O. Bowman died at Rowesville, S. C., on Wednesday, Nov. 15th, 1905, leaving a wife and one son. Dr. Bowman was a son of the late Dr. Orin N. Bowman, and after graduating in medicine at Bellevue Medical College, New York, in 1890, he succeeded his father in practice in the following year. His professional ability and his genial disposition won him rapid advancement. In his last illness he manifested a gentle patience under his affliction and met his end with quiet resignation and the sweet consciousness of having always done his

duty. Although for several years in failing health he labored on, and died at last from diphtheria, which he had contracted from a patient whose suffering he was endeavoring to alleviate. "Greater love hath no man than this, that a man lay down his life for his friends."

DR. ARTHUR S. LYNN.\*

Whereas death has visited our association and removed from its membership Dr. Arthur S. Lynn, who by his work in the Association and labors as a physician had endeared himself to us.

*Therefore, Be it resolved:*

I. That this Association has heard with profound regret of the death of Dr. Lynn and has ordered its appreciation of his work and its regret at his early demise be put upon record.

II. That this Association has sustained a great loss and the community the services of a conscientious, pains-taking physician.

III. That we recognize this as a dispensation of Providence and submit to His will.

IV. That a blank page in our minute book be inscribed to his memory.

V. That his family be notified of this action.

E. W. PRESSLEY, M. D.  
R. A. BRATTON, M. D.  
J. R. MILLER, M. D.

## NOTES AND REVIEWS.

### SURGERY.

T. P. WHALEY, M. D.

#### TIME AS AN ELEMENT IN ABDOMINAL SURGERY.

"In reviewing my failures in abdominal surgery for the past twenty years," says Dr. Maurice F. Richardson, in the *St. Paul Medical Journal*, "I am deeply impressed with the direct dependence of these failures upon the waste of time. It is not justifiable to waste precious moments in emergencies waiting for symptoms to confirm a diagnosis."

The symptoms which most of us regard as safe guides to surgical intervention do not appeal as widely to the profession as one would desire; hoping that acute abdominal symptoms are not as serious as they appear, that a few hours will

see the patient on the road to recovery, we are too much inclined to wait and see if the outlook is as bad as is feared. Such tendencies exist in all communities, and are responsible for the terrible consequences in abdominal emergencies. These disasters are especially common in rupture of the intestines, spleen and liver; from general peritonitis, from hemorrhage or both.

Most of the author's cases have been fatal owing to delay in getting the patient to the operating table or to delay in endeavoring to be sure that rupture had taken place. The most serious results frequently followed trivial injuries with insignificant symptoms at the onset, excepting pain. Many sudden disasters take place in the course of unsuspected disease, as in acute infection of the appendix, gall bladder and pancreas; perforations of unsuspected gastric or intestinal ulcer; twisting of pediculated tumors, intussusception and volvulus, without any premonitory signs, and if unrelieved they prove fatal. In such acute emergencies of doubtful nature it is not permissible to wait for a development of the lesion sufficient to make possible a positive diagnosis. In well-recognized lesions, which demand immediate investigation, time will not be lost. In the obscure case, in which such lesion is only suspected, time must not be lost. Finally, in cases in which the lesion is only suspected, time should not be lost, if that suspected lesion is one essentially fatal if not promptly relieved. Time for observation, diagnosis and prognosis can be profitably taken only in that class of cases in which the lesion is so well recognized as to justify delay.

The one symptom that best determines necessity for operation is pain; if we look on every case of severe abdominal pain as a case which demands immediate investigation, we shall avoid nine-tenths of the terrible misfortunes of abdominal disease, and as our experience in abdominal emergencies becomes larger we shall find that the number of unnecessary explorations diminishes and the number of successes increases.—W.—N. *Y. State Journal of Med.*, Dec., '05.

#### FRENCH CONGRESS OF SURGERY.

The eighteenth congress met at Paris during the first week in October, immediately after the first International Congress of Surgery. The subjects appointed for discussion were "Surgery of the Pancreas," "Reparative Surgery of the Face," and "Conservatism in Treatment of Traumatism of the Limbs." Nimier delivered the address on the last subject, emphasizing the fact that the modern surgeon should not only aim to preserve the injured parts by correcting the primitive lesions, applying the necessary bloodless measures, but he should also strive to restore function to the parts, with surgical intervention if necessary for this purpose from the very first, as soon as the diagnosis and the indications are established. Repair of the traumatic lesions is easily done, but functional repair requires persevering massage, mechanotherapy, hydrotherapy and electrotherapy. Massage has taken in surgery the place it deserves, but the other physical measures are still in a somewhat rudimentary condition. Hospitals should be better equipped for functional cures of traumatic lesions than is the case at present. Doyen reported the successful suture of a severed axillary vein. He used very fine, round needles, suturing at separate points, and fastening the stumps to the surrounding parts to prevent any traction on the suture. In case of



complete destruction of the axillary vein, he suggested that the external jugular might be transplanted on the stump of the shoulder, anastomosing it with the cephalic vein. To facilitate the suture of a vein, he advises suction cleansing of the field with an aseptic tube, connected with a suction pump. This aspirates every particle of blood, etc. Calot described a new method of treating congenital dislocation of the hip joint. He makes a very small incision, less than 2 cm. long, and introduces through this a special dilating instrument, with which, instead of cutting the stricture in the capsule, he stretches it. When the capsule is thus stretched, the dislocation can be easily reduced, as he has accomplished in two cases with excellent results. The discussion of surgery of the pancreas showed once more the difficulty of differentiating lesions in this organ. Garré said that he was able to save only 3 out of 11 patients with acute purulent inflammation or infarcts in the pancreas.—*Jour. A. M. A.*, Nov. 25, 1905.

## MATERIA MEDICA AND THERAPEUTICS.

J. L. NAPIER, M. D.

### MESOTAN.

Kieffer (in *Therapeutic Gazette*) recommends this preparation in the treatment of local rheumatic pains; he says: Mesotan depends for its action on absorption of this drug through the skin. . . . It has been shown that even though it exerts a general effect, it has a still more marked local action.

To secure its analgesic effect to painful area, he applies it locally; in the more acute pains the pure drug, in the dull, subacute or aponeurotic pains diluted with equal parts of olive oil, cottonseed oil, benzonated lard, or some such base, to prevent the dermatitis sometimes caused by its use. He observed no untoward effect from it.

## MARASMUS (MALNUTRITION) AND A TREATMENT THEREFOR.

George H. Chandler, Chicago, Ill., writes:—

Whether or no we accept the theory that atrophy of the intestinal tubules exists in every case of marasmus, we cannot shut our eyes to the fact that every other portion of the unfortunate child's anatomy does "waste" and that steadily and despite treatment of the ordinary type.

If therefore, you find a breast-fed infant gradually lose weight, take it away from the breast and put it upon one of these foods. Boil two or four pounds of the finest wheat flour, tied tightly in a cloth, for four full hours. Undo the cloth, split the skin of paste which will have formed and remove carefully from the dry hard ball of flour within. Break this into two or more pieces and grate or roll it to a fine powder. Bottle for use. Of this take one heaping teaspoonful, add milk sugar one teaspoonful and a pinch of salt. Mix to a cream with a little water and then add six ounces of milk and an equal amount of water. Bring to boiling point in an enameled pan and feed the usual quantity for age.

This is for the three months old child. For some few children it is best to reduce the milk

by one ounce, substituting water. In other and older children the reverse may be the case. For the infant of six months old, or up to nine months, use a tablespoonful of flour to half a pint of water, and the same of milk. If there is any constipation, substitute oatmeal water for water; and if weight does not increase as it should, add cream one teaspoonful per month of age.

This food the writer developed for one of his own children, and he has used it or ordered it in the most desperate cases, and not yet has it disagreed—and in at least a score of these instances every other food tried failed. The second food is really similar, but is *predigested*. A fluid digestant is on the market called Cereo, and any ordinary gruel (wheat, rice, barley, or oatmeal) can be almost instantly rendered absolutely assimilable by the addition of a teaspoonful to the pint. Children who cannot retain the slightest suggestion of milk food will get fat on this predigested cereal food. It is excellent in the summer diseases of the intestines and allowable even in *cholera infantum*.—*Exchange*.

## LARYNGOLOGY AND RHINOLOGY.

W. PEYRE PORCHER, M. D.

### THE TREATMENT OF NASAL CATARRH BY THE GENERAL PRACTITIONER.

In the *N. C. Medical Journal*, November, W. H. Wakefield, M. D., Charlotte, N. C., writes:

We will suppose that a patient requests your advice regarding his nasal catarrh, his persistent head cold, his ever present desire to cleanse his nasal cavities, his hawking and spitting which annoys him and his friends. He tells you he has been annoyed in this way for months, perhaps years, and the tendency is to grow worse. He will generally confess that he has used bottles of patent medicines. His voice probably tells you of impaired nasal function, and he has, no doubt, given you an exhibition of how he must hawk and spit in order to cleanse his post nasal space. Will you prescribe for this patient without an examination of the parts affected? Or, if you examine him, will you inspect his interior nasal cavities by the light of a window or glance into his pharynx under similar conditions. Treatment based on a diagnosis made in this way rarely affords the needed relief and is in part responsible for the often heard "Catarrh can't be cured."

In examining such a patient make the room dark as midnight, if possible, and inspect the interior nasal passages, using a nasal speculum, a good light and head mirror. Notice particularly the size and degree of firmness of the inferior and middle turbinates, also note the presence or absence of spurs or ridges on the septum and if it bends strongly to one side; note also the color of the parts and the amount of mucous or mucus present. Next, by means of a tongue depressor and pharyngeal mirror, inspect the pharynx and post nasal space. Note the amount of discharge and the presence or absence of swelling or thickening of the posterior ends of the turbinates. After this careful inspection the parts should be thoroughly cleansed by spraying them with some alkaline, antiseptic solution in a good atomizer

that will throw a coarse, vigorous spray. After thoroughly cleaning the cavities, apply to the turbinates and septum a solution of adrenalin or suprarenalin one to five thousand by means of a small pledgit of absorbent cotton or the atomizer and in two minutes inspect the cavities again. The extract of the suprarenal gland will have contracted the tissues and you can now obtain a much more extended view. Spurs or ridges on the septum, if present, are easily seen. Note carefully the amount of shrinking that has taken place on the turbinates, as the treatment depends largely on the behavior of the thickened parts under the action of the adrenalin. Given a case presenting large turbinates, interfering with nasal respiration, that shrink but little under suprarenal extract, the case belongs to class first, but if the shrinkage is marked, the case goes under the second heading.

Referring again to septal ridges or spurs. If these are of sufficient size to interfere with nasal respiration their removal is a necessity, but if they do not hinder respiration, they rarely do harm. If the septum be markedly deflected, practically closing one nostril, the case belongs to class "first." If at this inspection you find a turbinate, septal ridge or spur or deviated septum or other abnormality of size sufficient to narrow the space so that a reasonable degree of respiration is not possible, it is a pious hope rather than a reasonable expectation, to anticipate much relief from the catarrhal symptoms without first removing the abnormalities by surgical means, and this regulates all such cases into class first. If adenoids or enlarged tonsils are present, (and you will be asked to treat many cases of nasal catarrh in which these are present, and probably are the exciting cause) their removal is imperative if a cure is to be expected, and the case belongs to class first.

By this time you are probably asking what cases will go under class second? There are plenty of them to try your patience. If on inspection after the use of adrenalin, you find the formerly enlarged turbinates much shrunken and the breathing space normal, the case requires no surgery. This class of cases is best treated by cauterizing the inferior turbinates by means of chromic or nitric acid or electro cautery. Personally, I prefer chromic acid to nitric as it is readily limited to the points which it is desired to cauterize. Always anesthetize the parts thoroughly by cocaine or eucaine B., before cauterizing. Twist a small piece of cotton on the tip of a small probe, moisten the cotton and apply one side to a few chromic acid crystals; in a second or two they are dissolved and can easily be applied again to the surface of the turbinate. Cauterize two or three lines on its surface from before backward as far as needed, spraying the nose after each passage of the probe so as to wash off any small surplus of the acid that may have adhered to the tissues. If the parts were fully anesthetized the patient has not suffered any pain, not even discomfort. Actual cautery can also be used to advantage over chromic acid, except in the worst cases, when it is advisable to burn through the membrane to the bone. In using nitric acid, care must be used or it will flow over the surface of the turbinate and destroy considerable secreting surface, a result to be vigorously guarded against.

Given a case of nasal catarrh that comes under class second, the doctor should cauterize the turbinates if needed, as already described, and if the naso-pharynx is involved appropriate local treatment should be applied by the physician. But

these patients will not come daily or twice daily to our office for treatment, hence we must teach them how to make applications themselves.

One obstacle to the successful treatment of nasal catarrh is the failure on the part of the patient to make a thorough application of the remedies and the tendency to discontinue the treatment too early. Pains must be taken to instruct how to use the atomizer and stress must be laid on the necessity of thorough cleansing of the nasal passages at stated intervals.

The post nasal space and pharynx should also have attention when they are involved. Turn the tip of the instrument upward to a right angle, pass the tip over the tongue and behind the soft palate and thoroughly wash the parts. The physician should have the patient do this in his office and then inspect the parts in order to see that they have been thoroughly cleansed. In many instances you will be surprised to find, after the spraying, considerable discharge on the floor of the nose or clinging to the turbinates. There is only one rule in these cases, and that is to thoroughly cleanse the cavities, using as a cleansing agent an alkaline solution to keep the parts clean so that nasal respiration is free. After the cleansing solution, a protective spray of oil is often beneficial, especially so if used by the patient before exposing himself to severe weather. In children the little patients must be watched to see that the nose is kept clean.

Local treatment is not sufficient to cure many of these cases, the nasal disturbance being due to a vicious condition in some other organ or organs.

In addition to seeing that local treatment is properly carried out, study each of your patients carefully. The strong, vigorous patient who takes cold easily probably eats too much or the bowel is sluggish. Insist on a cool sponge bath followed by a brisk rub with a rough towel every morning; give him to understand that overeating must stop if he desires to cure his catarrh, and in addition correct the habit of constipation.

Many of your patients will not be vigorous and full blooded—they are of sedentary habits, working in badly ventilated, over or overheated rooms, many of them being dyspeptic. Pay particular attention to the digestion disturbance. Insist that each and every mouthful of food be chewed until it is a fluid in the mouth; also insist on proper ventilation of their rooms day and night; put them on daily tepid sponging of the whole body, followed by a brisk rubbing to increase the activity of the skin, daily make the water a little cooler until the sponging is done with cold water. In children the same rules hold good, but more of them need tonics, such as cod liver oil, or better, a cordial of the oil containing its extratives minus the oil, syrup of iodide of iron, Fowler's or Donovan's Sol. of Arsenic, or a combination of iron, quinine and strychnine.

To recapitulate: Before attempting to treat nasal catarrh, first make a careful diagnosis.

Remove or cause to be removed all impediments to easy nasal respiration.

Keep the parts thoroughly cleansed by means of a non-irritating antiseptic.

Correct any habits on the part of the patient that may act as exciting cause.

Always teach the patient how to use the Atomizer.

Administer such tonic remedies as may be indicated in each case, prominent among which are the morning cool sponge and rough rub and



the proper ventilating of work rooms and sleeping apartments.

I am of the opinion that nasal catarrh can be cured in the great majority of cases if these means are intelligently and persistently employed.

"Of course it must be remembered that there are many conditions in the nose which are all termed catarrh, besides strophic rhinitis and hypertrophic, there are polypi and other tumors in the nose, and all the purulent diseases of the accessory sinuses. It would not be wise for the general practitioner to attempt to relieve all of these conditions, unless he had all the necessary appliances, because many of them are exceedingly intricate even under the most advantageous circumstances and with every known appliance for their treatment.

#### FORMALIN IN THE TREATMENT OF DISEASES OF THE EAR, NOSE AND THROAT.

In *The Laryngoscope*, November, Otto Stein, M. D., Chicago, Ill., writes:

I was first led to employ this drug in a case of long standing muco-purulent discharge of the ear, and was so pleased with the immediate results obtained that I began using it in a variety of ear affections. It demonstrated its worth as a drug to prevent the growth of and as a power to destroy bacilli. As a means to prevent the development of the bacteria of putrefaction, and to prevent the growth of the various parasitic growths found within the auditory canal, in otomycosis, it has no equal. Most gratifying results will be obtained when used to check the foul odor existing in many cases of chronic suppurative ear disease.

From the results obtained in the treatment of certain affections of the respiratory passages, we have ample proof of its effectiveness as an antiseptic. Excellent results have been secured in the treatment of whooping cough and pulmonary tuberculosis, but I have had no personal experience with it in either of them. In the anginas accompanying the various exanthemata, and in diphtheria its employment is apparent. In tubercular laryngeal disease it is to-day one of the best means we possess for treating this affection. Personally I have used it in the various manifestations of the disease many times, and the conclusions I have arrived at after this experience warmly endorses its employment in such affections. It has been recommended in the infiltration stage of the disease by direct injection into the infiltrated area. I have not used it in this way. But in the ulcerative stage it certainly exerts most promising results. It is my practice to first cleanse the ulcers, then spray a ten per cent. cocain solution into the larynx, to be followed in five or ten minutes with a cotton applicator well moistened with a five to ten per cent. solution of formalin in water. The previous application of the cocain robs the patient of any smarting otherwise present as a result of the formalin. The treatments are repeated two or three times a week, and never result in any unpleasant symptoms. Many different combinations of formalin are used, but my method is to dilute with water. A solution suggested by Lake has proven successful in some hands. It is composed of carbolic acid, ten parts, formalin ten parts; lactic acid, fifty parts, and water thirty parts. Par-

aform, a powdered form of formalin, can also be used.

Formalin may be incorporated in mouth wash and gargle solutions in the strength of one-half per cent. In the lacunar type of tonsil disease it can be used in from two to five per cent. solutions. A one to two per cent. solution can be used in the various manifestations of nasal disease, like tubercular and syphilitic ulcerations, atrophic rhinitis with ozema and in suppurative sinusitis. It is advisable in all such cases to first clean the affected surface, and then apply a two or four per cent. cocain or eucaïn solution, in order to obviate the pungent effect of the formalin. In vaso-motor rhinitis Ballenger incorporates the cocain with the formaline as follows: Formalin, one-half per cent.; cocain, two per cent.; and he then makes but one application with a spray.

#### CLOSURE OF THE OSTIUM MAXILLARE.

Johannes Martin.—*Monatsschr. f. Ohrenh.*, Berlin, February, 1905.

Three case of antrum disease are reported, which healed rapidly after puncture through the lower meatus, and irrigation. In all the cases considerable pressure was required to start the flow of fluid through the antrum, showing that there was some obstruction at the ostium. The author believes that there are many cases in which, during an acute rhinitis, the natural orifice of the antrum becomes obstructed through swelling of the mucous membrane. The veins of the antrum leave the latter through the natural opening. Hence, when obstruction occurs at this point, a venous stasis takes place in the antrum, resulting in swelling and oedema of its lining membrane. In this way the obstruction is kept up, and the antrum becomes filled with secretion. The rapid cure after puncture is thus easily explained.

#### MISCELLANY.

#### PROPRIETARY MEDICINES, PATENT MEDICINES, NOSTRUMS, AND SECRET SYNTHETICS.

We must call attention to the confusion of terms so generally used in the literature upon this subject of proprietary remedies, patent medicines and nostrums. There is great need for clearness in the selection of terms which will definitely convey the intended meaning of those who speak or write upon this question, which has become such a live one to the general public as well as to the medical profession. The authority for the proper use of the words hereinafter defined is based upon the definitions given in the dictionary, and the United States patent law. A proprietary medicine is an anti-

cle which any person or firm has the exclusive right to manufacture or sell; which definition includes a medicine of known formula or published process of manufacture, as well as a medicine of unknown formula or secret process of manufacture. The word proprietary should only be used generically, and should never be limited in its application as a synonym of the word nostrum. Proprietary medicines include: I. Patent medicines, all of which are of known process of manufacture; II. Pharmaceutical mixtures of known quantity and quality of ingredients; III. Nostrums, such as secret pharmaceutical mixtures, and the so-called synthetics, of secret formula protected by a trademark.

A patent medicine is a new and useful definite chemical compound of known formula, the process of manufacture is made public in the patent papers issued by the Government; therefore, all patent medicines are ethical. A nostrum is a medicine, the composition of which is secret, a quack medicine, or any recipe of charlatan character.

The trademark protects a class of secret synthetics which are nostrums, they being secret mixtures of some coal-tar product, advertised with a formula such as  $C_1$ ,  $H_2$ ,  $N_3$ ,  $O_4$ . They are not patented, because they cannot conform to the patent law which demands that they shall be new and useful, definite chemical compounds.

The public and the profession have a right to be protected from the fraud practiced by the exploiters of nostrums which represent the only class of medicines offered to the medical profession which should be condemned as an insult to its intelligence and honesty. Any internal or external medicine, the formula of which does not state the quantity of its ingredients, and in the case of a synthetic, which does not state the process of its manufacture, is a nostrum or secret proprietary medicine. All nostrums thrive on false statements as to their therapeutic value. And it is the nostrum or secret proprietary venders who have profited by the confusion of terms used in articles written

by the authorities in medicine, who should know better than to play into the hands of the nostrum people, who must be considered as parasites on individual and public health.

Within two years articles have appeared by able teachers of scientific medicine, which illustrate the confusion of terms referred to. Transactions of State medical societies and medical journals contain the articles from which the following quotations are made:

I. "The wide use of many proprietary pills or mixtures, is distinct evidence of the great power of foolishness and fraud even when directly opposed to honesty and instructed wisdom."

II. "There are no hard and fast lines which separate patent from proprietary remedies. In their secrecy of composition and method of exploitation they are comparable."

III. "The patent medicines are more particularly directed to the lay public and therefore use the public press as the medium of advertising, while the proprietary literature is addressed more particularly to the medical public."

IV. "If there is any apology for the use of proprietary medicines, it must be due to some deficiency in the physician himself, either to his lack of knowledge of chemistry and pharmacology and physiology and clinical therapeutics, or to his inertia."

V. "The difference between a proprietary and a patent medicine is more apparent than real. There is no good excuse for using these preparations."

These are fair extracts from the articles which do more harm than good, as many of the most valuable remedies used by physicians are proprietary medicines, and should not be condemned as nostrums. Many writers have strongly condemned the use of patent medicines in the face of the fact that all medicines now protected by a patent granted by our Government are ethical because the process of their manufacture is known. Recently an editorial and article have been published which distinguishes between a patent and a patented medicine; such distinction is



of recent origin, and if not killed in its infancy will surely lead to greater confusion than that which now exists in the minds of the profession and of the public.

The old prejudice against a patent medicine dates from the time when a prescription of a simple or compound mixture could be patented, but such mixtures have not been patented in many years, so that the patent medicines of to-day represent *only* new and useful definite chemical compounds, the patent covering the process of manufacture, and any competent pharmaceutical chemist, by following the process described in the patent, can reproduce the identical preparation found upon the market; but the patent protects against a commercial use of such published process, which in being made public meets every condition necessary to make a patent medicine ethical.

The subject of monopoly in drugs and other therapeutic agents is a sociological one, and not essentially a medical question. To use the word "patent" as the synonym, and the word "patented" as the antonym of nostrum, as is being done by some of the workers in this field, is to increase rather than to clear up the fog which surrounds this important subject. The literature is full of such tautology as secret nostrums; the word "nostrum" means secret remedy, which makes qualifying it by the word "secret" equivalent to saying that *one should heed the voice of the vox populi*. The reader often leaves the several articles in the medical journals upon the question of proprietary remedies, patent medicines and nostrums, and the discussion of the subject as reported in the transactions of the several State medical societies, in a condition of mind best described as confusion worse confounded; which is largely due to the careless use of terms, and the questionable remedies suggested, for this evil. It is not unusual to read in many of the discussions before medical societies, which have been reported within the past five years, such advice as: Why not limit the prescribing of physicians to the articles mentioned in the pharmacopœia? Or should not the profession agree not to use

any patent medicine; or that all proprietary medicines should be excluded from the advertising pages of medical journals, and should not be used by physicians? It is such advice which supplies the nostrum journals with the telling arguments in opposition to this great work, which is so often made ridiculous through misstatement and misunderstanding. The medical profession should be in possession of a criterion which should help it to decide which of the many samples of medicines left in a physician's office should find their way to the trash-basket. Samples of secret mixtures, protected by trademark, but not patented, which are exploited as definite chemical compounds, or coal-tar synthetics—should be considered as an insult to the intelligence of every physician receiving them. The information about such articles, so often limited to the statement that they do not depress the heart, at once suggests that they are more or less dangerous mixtures of acetanilid exploited as definite chemical compounds with popular names valuable only as commercial assets. Often the workmen in nostrum manufactories who know the secret of some special mixture will exploit such mixture under new, popular names, furnishing formulas such as  $C_5$ ,  $H_{10}$ ,  $O_{20}$ ,  $N_{30}$ , and then circularize and sample the medical profession, expecting physicians to accept such samples, and prescribe such nostrums or secret proprietary medicines, to their patients, which represent, as all nostrums do, fraud as to their composition, and false statements as to their therapeutic value.

To sum up: I. Proprietary remedies include ethical preparations and nostrums.

II. All medicines protected by a patent are ethical.

III. Nostrums include secret proprietary mixtures and secret synthetics protected by the trademark law.

All samples of secret medicines should be deposited in the trash-basket, as every scientific physician should know the quantity of the ingredients in the mixture or mixtures which he uses, and should beware of secret synthetics.

The Council of Pharmacy of the Amer-

ican Medical Association has the courage of its conviction and is doing splendid work in educating the medical profession along the lines of scientific medicine, and away from the nostrum evil, and, with the co-operation of the *Ladies' Home Journal*, *Everybody's Magazine* and *Collier's Weekly*, the same thing is being done for the general public. By the study of pharmacology the United States Pharmacopœia will come into more general use and scientific medication will be correspondingly advanced throughout the United States.—E. ELIOT HARRIS, M. D., in *N. Y. State Journal of Medicine*.

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### THE RELATION BETWEEN COUNTY AND STATE SOCIETIES.

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The present plan of organization was adopted in 1901. In the four years that have passed remarkable and unexpected progress has been made in uniting and organizing the profession in the United States. A comparison of present conditions in any part of the country with those of four years ago will show that a most welcome improvement has occurred. Without exception, the membership in the State Associations has largely increased.

The cause for this increase in membership is the recognition and exaltation of the County Society. In the scheme of organization, the local association of physicians, the County Society, is the unit. It is the only door to membership in the State and in the American Medical Associations. There is, in reality, no State Association, there is only an aggregation of County Societies. There is no American Medical Association as a separate organization, it is formed of the union of all the State Associations. In this organization trio the County Society alone is basic and fundamental. Both the State and the American Medical Association rest on it. They can only grow and endure as the County Societies prosper.

These principles are fundamental and obvious, yet they demand reiteration to remove misunderstandings. The idea is

still prevalent that the American Medical Association is an independent body, with its own aims and purposes. It is difficult to remove from the minds of many members the idea that the State Association is a separate organization of which one can be a member or not, just as he chooses. Yet it is perfectly obvious that, since the State Association is composed of the aggregate membership of all the component County Societies, membership in the County Society includes and carries with it membership in the State Association. In the same way there are no separate, distinct dues to the State Society. Each member of a County Society pays his yearly dues for membership. The State Society levies an annual per capita assessment on the entire membership and collects this tax, not from the individual member, but from the County Secretary, who pays the assessment on each member in good standing from the treasury of the Society. State Secretaries or Treasurers should not collect dues from individual members; they should always come through the County Secretary.

In other words, County Society dues should be the amount necessary for local purposes plus the State Association per capita tax. To illustrate: Before reorganization in Illinois the Chicago Medical Society had a membership of nine hundred and an annual due of five dollars. The Illinois State Medical Society had a membership of four hundred and an annual due of three dollars. When Illinois reorganized, an annual per capita assessment of \$1.50 per member was levied. The Treasurer of the Chicago Medical Society pays annually to the Treasurer of the Illinois State Medical Society \$1.50 for each member in good standing. This leaves \$3.50 per member in the Society treasury. The membership of the Chicago Medical Society is now 1,800 and that of Illinois State Society 4,800.

The attention of County Secretaries should be called to the following general principles:

1. Membership in a component County Society includes and carries with it membership in the State Association.



2. There are no individual dues for State membership. There is only an annual per capita assessment.

3. County Society dues should be the amount necessary for the local organization plus the amount necessary for the State organization. If the County Society needs \$2.50 per member, and the State House of Delegates levies a \$1.50 tax, then the County Society dues should be \$4.00.

4. All Society dues should be paid to the County Secretary, who should forward to the State Treasurer or Secretary the assessment of the local Society.

An observance of these principles will avoid the anomalous situation of a member being in good standing in his County Society and in arrears in the State Association, or marked "delinquent" on the County list and "O. K." on the State roster, which is an impossible condition under the present system of organization.

—*The Councilors' Bulletin.*

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#### COLLIER'S CAMPAIGN.

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*Collier's Weekly* has inaugurated a vigorous campaign against "patent" medicines. A series of ably written and convincing articles on these preparations by Samuel Hopkins Adams is running through the current numbers of this publication. The issue for Oct. 28 contains an article called "Peruna and Bracers," being devoted especially to so-called remedies which are principally composed of poor whiskey. The subject is excellently and clearly presented. Facts long known to the medical profession are demonstrated in a manner convincing to the laity. In many parts of the country physicians are leading or aiding in the formation of subscription clubs for *Collier's Weekly*, so as to place it in the hands of prominent members of the laity. This publication and its editors merit the individual support of the medical profession. By widely disseminating the facts regarding such preparations much can be done to prevent and do away with secret

tippling of alcohol-containing preparations, as well as the unconscious growth of alcoholism, especially among women. —*The Councilors' Bulletin.*

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#### COUNCIL ON PHARMACY AND CHEMISTRY, AMERICAN MEDICAL ASSOCIATION.

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##### OFFICIAL REPORT ON ACETANILID MIXTURES.

The following report has been approved by the Council.

*To the Council on Pharmacy and Chemistry of the American Medical Association:*

In response to the request of your chairman, we have investigated the below-mentioned preparations and report as follows:

Specimens of the articles were bought in different cities in the open market, and in the original, sealed packages, and were analyzed by some of us or under our direction. Each article was examined by at least two chemists, and some were subjected to several analyses. While certain of the preparations are represented as being chemical compounds, the specimens were all found to be mixtures; the principal ingredient being acetanilid. The percentage proportions of acetanilid given below are the minimum obtained by any of the analysts.

Soda and ammonia, combined with carbonic acid, are calculated and reported as sodium bicarbonate and as ammonium carbonate (U. S. P.), respectively. Salicylic acid is calculated and reported as Sodium salicylate. Diluents and other constituents than those reported were not determined.

##### AMMONOL.

According to the analyses of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid	Sodium Bicarb.
50.	25.

## Ammonium Carb.

20.

## ANTI-KAMNIA.

According to the analyses of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid	Caffein	Citric Acid
68.	5.	5.
Sodium Bicarb.		
20.		

## KOEHLER'S HEADACHE POWDERS.

According to the analyses of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid	Caffein
76.	22.

## ORANGEINE.

According to the analyses of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid	Sodium Bicarb.	Caffein
43.	18.	10.

Other constituents said to be present were not determined.

## PHENALGIN.

According to the analyses of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid	Ammonium Carb.
57.	10.
Sodium Bicarb.	
29.	

Certain packages of Phenalgin were purchased which on analysis did not show ammonium carbonate.

## SALACETIN.

According to the analyses of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid	Sodium Salicylate
43.	20.
Sodium Bicarb.	
21.	

We recommend that this report be printed in *The Journal* of the American Medical Association.

Respectfully submitted,

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W. A. PUCKNER, Ph.G.,  
H. W. WILEY, M.D., Ph.D.  
S. P. SADTLER, Ph.D.,  
J. STIEGLITZ, Ph.D.,

Committee on Chemistry, Council on Pharmacy and Chemistry of the A. M. A.

—*Journal A. M. A.*

THE 8th ANNUAL SESSION OF THE TRI-STATE MEDICAL ASSOCIATION OF THE CAROLINAS AND VIRGINIA MEETS AT WHITE STONE LITHIA SPRINGS, S. C., LAST OF FEBRUARY OR FIRST OF MARCH, 1906.

LAURENS, S. C., Nov. 13th, 1905.

Dr. H. A. Royster of Raleigh, N. C., is President, and Dr. Rolfe E. Hughes of Laurens, S. C., is Sec'y. and Treas.

The following appointments have been made:

## CHAIRMEN OF SECTION FOR NORTH CAROLINA.

*Medicine*—Dr. E. T. Dickinson, Wilson, N. C.

*Surgery*—Dr. D. T. Tayloe, Washington, N. C.

*Obstetrics*—Dr. C. A. Julian, Thomasville, N. C.

*Gynecology*—Dr. J. E. Stokes, Salisbury, N. C.

*Eye, Ear, Nose and Throat*—Dr. C. V. Brawley, Salisbury, N. C.



# SOUTH CAROLINA.

*Medicine*—Dr. F. J. Carroll, Summer-ville, S. C.  
*Surgery*—Dr. T. L. Potts, Spartanburg, S. C.  
*Gynecology*—Dr. R. A. Cathcart, Char-leston, S. C.  
*Obstetrics*—Dr. Frank Lander, William-ston, S. C.  
*Eye, Ear, Nose and Throat*—Dr. W. P. Porcher, Charleston, S. C.

# VIRGINIA.

*Medicine*—Dr. L. G. Pedigo, Leather-wood, Va.  
*Surgery*—Dr. J. Shelton Horsley, Rich-mond, Va.  
*Gynecology*—Dr. W. F. Anderson, Farmville, Va.  
*Obstetrics*—Dr. J. M. Robinson, Dan-ville, Va.  
*Eye, Ear, Nose and Throat*—Dr. J. F. Woodward, Norfolk, Va.

# NECROLOGICAL COMMITTEE.

Dr. J. A. Burroughs, Asheville, N. C.;  
 Dr. Davis Furman, Greenville, S. C., and  
 Dr. W. L. Robinson, Danville, Va.

# INVITATION COMMITTEE.

Dr. G. DeFoix Wilson, Spartanburg,  
 S. C.; Dr. J. S. Irvin, Danville, Va.;  
 Dr. J. W. Long, Greensboro, N. C.

# ON PUBLICATIONS.

Dr. G. T. Sikes, Grissom, N. C.; Dr.  
 T. P. Whaley, Charleston, S. C., and Dr.  
 C. M. Edwards, Richmond, Va.

# ON DELINQUENTS.

Dr. J. F. Swann, Cunningham, N. C.;  
 Dr. W. C. Black, Greenville, S. C., and  
 Dr. L. G. Frazier, Port Norfolk, Va.

# SUBJECTS FOR GENERAL DISCUSSION,

# “RHEUMATISM”—LEADERS OF DEBATE.

Dr. J. P. Munroe, Davidson, N. C.;  
 Dr. J. H. Allen, Spartanburg, S. C.; Dr.  
 C. B. Earle, Greenville, S. C., and Dr.  
 Virginius Harrison, Richmond, Va.

# AFFILIATED COUNTY SOCIETIES WITH MEMBERS.

(The Secretary begs to announce that  
 this list will appear for several issues, in  
 order to make the same as complete as  
 possible.

He requests that he be notified prompt-ly  
 of any errors or omissions.)

# ABBEVILLE.

(ABBEVILLE COUNTY MEDICAL SOCIETY.)

*Secretary, C. C. Gambrell, Abbeville.*

J. A. Anderson.....	Autreville.
J. R. Bell.....	Due West.
P. R. Black.....	Mt. Carmel.
J. B. Britt.....	Troy.
J. M. Carlton.....	Mt. Carmel.
C. C. Gambrell.....	Abbeville.
F. E. Harrison.....	Abbeville.
L. T. Hill.....	Abbeville.
J. W. Keller.....	Abbeville.
T. O. Kirkpatrick.....	Lowndesville.
D. S. Knox.....	Autreville.
Frank Lander .....	Williamston.
S. Mare .....	Anderson.
G. A. Neuffer.....	Abbeville.
W. H. Pepper .....	Anderson, R. F. D
J. M. Richardson .....	Anderson.
M. W. Strickland.....	Pelzer.
J. W. Wideman.....	Due West.
J. D. Wilson.....	Lowndesville
W. W. Wilson .....	Williamston.

# ANDERSON.

(ANDERSON COUNTY MEDICAL ASSOCIATION.)

*Secretary, J. B. Townsend, Anderson.*

Frank Ashmore .....	Anderson.
J. L. Gray.....	Anderson.
J. C. Harris.....	Anderson.
W. R. Haynie.....	Belton.
B. A. Henry.....	Anderson.
W. S. Hutcherson.....	Anderson, R.F.D.
W. H. Nardin.....	Anderson.
W. H. Nardin, Jr.....	Anderson.
R. P. Ransom.....	Williamston.
J. B. Townsend.....	Anderson.
R. G. Witherspoon.....	Anderson.

# AIKEN.

(AIKEN COUNTY MEDICAL SOCIETY.)

*Secretary, W. C. R. Turnbull, Aiken.*

T. G. Croft.....	Aiken.
B. S. Dunn.....	Aiken.
T. P. Edwards.....	Graniteville.
L. B. Etheridge.....	Wagner.
W. S. Eubanks.....	Talatha.

J. I. Green.....	Bath.
11. T. Hall.....	Aiken.
M. M. Lecroy.....	Langley.
W. E. Mealing.....	North Augusta.
C. F. McGahan.....	Aiken.
J. A. Millhouse.....	Perry.
V. Mott .....	Aiken.
H. J. Salley.....	Salley.
W. H. Shaw.....	Langley.
C. A. Teague.....	Graniteville.
W. C. R. Turnbull.....	Aiken.
J. R. A. Whitlock.....	Kitchen's Mill.
W. A. Whitlock.....	Kitchen's Mill.
W. D. Wright.....	Langley.
B F. Wyman.....	Aiken.
J. F. Wyman.....	Aiken.
H. H. Wyman, Sr.....	Aiken.
H. Hastings Wyman, Jr.....	Aiken.
Harry H. Wyman.....	Aiken.

# BARNWELL.

(BARNWELL COUNTY MEDICAL SOCIETY.)

*Secretary, L. F. Bonner, Blackville.*

L. F. Bonner.....	Blackville.
D. K. Briggs.....	Blackville.
S. R. Hickson.....	Kline.
R. C. Kirkland .....	Barnwell.
J. A. McCreary.....	Williston.
E. L. Patterson.....	Barnwell.
W. C. Smith.....	Williston.

# CHARLESTON.

(MEDICAL SOCIETY OF SOUTH CAROLINA.)

*Secretary, J. C. Mitchell, Charleston.*

C. P. Aimar.....	Charleston.
R. Alston .....	Charleston.
A. E. Baker.....	Charleston.
L. D. Barbot.....	Charleston.
R. L. Brodie, Hon.,.....	Charleston.
A. J. Buist.....	Charleston.
J S. Buist.....	Charleston.
J. W. Burn.....	Charleston.
R. S. Cathcart.....	Charleston.
W. P. Cornell.....	Charleston.
H. W. DeSaussure.....	Charleston.
J. Frampton .....	Mt. Pleasant.
Jno. Forrest .....	Charleston.
J. P. Galvin.....	Charleston.
J. M. Green.....	Charleston.
W. H. Huger.....	Charleston.
B. W. Hunter.....	Charleston.
H. P. Jackson.....	Charleston.
F. B. Johnson.....	Charleston.
W. H. Johnson.....	Charleston.
R. S. Kirk.....	Charleston.
C. W. Kollock.....	Charleston.
Jos. Maybank .....	Charleston.
Wm. Mazzyck .....	Charleston.
A. Memminger .....	Charleston.

J. C. Mitchell .....	Charleston.
G. McF. Mood.....	Charleston.
Lane Mullally .....	Charleston.
E. F. Parker .....	Charleston.
F. L. Parker, Hon.,.....	Charleston.
W. P. Porcher .....	Charleston.
C. M. Rees.....	Charleston.
Edw. Rutledge .....	Charleston.
T. M. Scharlock .....	Charleston.
C. H. Schroeder.....	Charleston.
Manning Simons, Hon.,.....	Charleston.
T. G. Simons, Hon.,.....	Charleston.
A. R. Taft.....	Charleston.
J. S. Taylor.....	Charleston.
T. P. Whaley.....	Charleston.
G. F. Wilson.....	Charleston.
J. LaR. Wilson.....	Charleston.
Robt. Wilson .....	Charleston.

# CHEROKEE.

(CHEROKEE COUNTY MEDICAL SOCIETY.)

*Secretary, B. L. Allen, Gaffney.*

B. L. Allen.....	Gaffney.
W. Anderson.....	Blacksburg.
B. R. Brown.....	Gaffney.
S. B. Crawley.....	Gaffney.
J. T. Darwin.....	Gaffney.
S. H. Griffith.....	Gaffney.
C. A. Jeffries.....	Gaffney.
C. M. Littlejohn.....	Gaffney.
R. F. McKown.....	Cherokee Falls.
J. N. Nesbit.....	Gaffney.
W. L. Settlemyer.....	Gaffney.
M. W. Smith.....	Gaffney.
B. B. Steedly.....	Gaffney.

# CHESTER.

(CHESTER COUNTY MEDICAL SOCIETY.)

*Secretary, W. B. Cox, Chester.*

A. F. Anderson.....	Laceyville.
J. M. Brice.....	Chester.
W. B. Cox.....	Chester.
F. M. Durham.....	Blackstock.
R. L. Douglas.....	Rodman.
J. G. Johnson.....	Chester.
G. W. Jordan.....	Chester.
T. B. Kell.....	Catawba.
H. E. McConnell.....	Chester.
S. G. Miller.....	Chester.
S. W. Pryor.....	Chester.
W. DeK. Wylie.....	Richburg.
A. M. Wylie.....	Chester.
J. P. Young.....	Chester.

# COLLETON.

(COLLETON COUNTY MEDICAL SOCIETY.)

*Secretary, Chas. S. EsDorn, Walterboro.*

Riddick Ackerman.....	Walterboro.
W. B. Ackerman.....	Walterboro.



C. S. EsDorn.....Walterboro.  
J. T. Taylor.....Adams Run.  
Benjamin Willis .....Walterboro.

## DORCHESTER.

(DORCHESTER COUNTY MEDICAL ASSOCIATION.)

*Secretary, J. B. Johnston, St. George's.*

W. M. Carn.....St. George.  
J. T. Carter.....Branchville.  
A. H. Hayden.....Summerville.  
P. L. Horn.....St. George.  
A. R. Johnston.....Reevesville.  
J. P. Johnston.....St. George.  
P. M. Judy.....St. George.  
H. B. Lee.....Summerville.  
J. P. Mellard.....St. George.  
J. S. Wimberly.....Branchville.

## FLORENCE.

(FLORENCE COUNTY MEDICAL SOCIETY.)

*Secretary, Wm. Ilderton, Florence.*

A. G. Eaddy.....Timmons ville.  
N. W. Hicks.....Florence.  
Wm. Ilderton.....Florence.  
T. C. Johnson.....Mars Bluff.  
F. H. McLeod .....Florence.  
W. E. Mills.....Timmons ville.

## GREENVILLE.

(GREENVILLE COUNTY MEDICAL SOCIETY.)

*Secretary, J. A. Hayne, Greenville.*

T. W. Bailey.....Greenville.  
W. C. Black.....Greenville.  
G. H. Bottum.....Greenville.  
E. W. Carpenter.....Greenville.  
L. G. Corbett.....Greenville.  
C. B. Earle.....Greenville.  
J. B. Earle.....Greenville.  
T. T. Earle.....Greenville.  
Davis Furman.....Greenville.  
C. T. J. Giles.....Greenville.  
B. F. Goodlett.....Travelers Rest.  
R. E. Houston.....Greenville.  
F. G. James.....Greer.  
J. W. Jervey.....Greenville.  
C. C. Jones.....Greenville.  
G. L. Martin.....Greenville.  
W. Y. McDaniel.....Taylors.  
J. E. McKinney.....Greenville.  
W. L. Mauldin, Jr.....Greenville.  
W. S. Pack.....Greenville.  
L. L. Richardson.....Simpsonville.  
H. L. Shaw.....Fountain Inn.  
R. D. Smith.....Greenville.  
L. C. Stevens.....Greenville.  
G. T. Swandale.....Greenville.  
J. R. Ware.....Greenville.  
A. Wallace .....Greenville.  
C. Q. West.....Greenville.  
A. White .....Mauldins.  
W. E. Wright.....Greenville.

## GREENWOOD.

(GREENWOOD COUNTY MEDICAL SOCIETY.)

*(Secretary, J. B. Hughey, Greenwood.)*

W. P. Barratt.....Greenwood.  
E. O. Devlin.....Verdery.  
R. B. Epting.....Greenwood.  
J. C. Harper.....Greenwood.  
J. E. Hughey .....Greenwood.  
E. O. Jenkins.....Troy.  
W. T. Jones.....Janes.  
John Lyon .....Ninety-Six.  
G. P. Neel.....Greenwood.  
W. P. Turner.....Coronaca.  
W. Townes.....Cokesbury.  
S. L. Swygert.....Greenwood.  
A. H. Wideman.....Bradley.

## HAMPTON.

(HAMPTON COUNTY MEDICAL SOCIETY.)

*Secretary, C. A. Rush, Hampton.*

J. W. Colson.....Varnville.  
J. L. Folk.....Brunson.  
N. C. Johnson.....  
M. B. Monsen.....Luray.  
C. R. Peebles.....Estill.  
C. A. Rush.....Hampton.  
Southward Smith .....Brighton.  
C. P. Vincent.....Varnville.  
C. P. Walter.....Crockettsville.

## KERSHAW.

(KERSHAW COUNTY MEDICAL ASSOCIATION.)

*Secretary, S. C. Zemp, Camden.*

S. F. Brasington.....Camden.  
W. J. Burdell.....Lugoff.  
A. W. Burnet.....Camden.  
J. W. Corbett.....Camden.  
W. R. Clyburne.....Camden.  
W. J. Dunn.....Camden.  
J. T. Hay.....Boykins.  
A. A. Moore.....Camden.  
S. C. Zemp.....Camden.

## LEE.

(LEE COUNTY MEDICAL SOCIETY.)

*Secretary, L. H. Jennings, Bishopville.*

A. C. Baskins.....Bishopville.  
A. H. Brown.....Rural.  
J. B. Bullock.....Lucknow.  
E. F. Darby.....Magnolia.  
J. D. Foxworth.....Smithville.  
B. L. Harris.....St. Charles.  
L. H. Jennings.....Bishopville.  
J. B. Manning.....Bishopville.  
B. McLaughlin .....Bishopville.  
R. Y. McLeod.....Bishopville.  
J. E. McLure.....Bishopville.  
J. W. Tarrant.....Magnolia.

LEXINGTON.

(LEXINGTON COUNTY MEDICAL SOCIETY.)

*Secretary, J. J. Wingard, Lexington.*

C. W. Barron.....	New Brookland.
D. M. Crosson.....	Leesville.
J. P. Drafts.....	Gilbert.
F. R. Geiger.....	New Brookland.
Theo. A. Quattlebaum.....	Batesburg.
W. Price Timmerman.....	Batesburg.
J. J. Wingard.....	Lexington.

MARION.

(MARION COUNTY MEDICAL SOCIETY.)

*Secretary, H. A. Edwards, Latta.*

B. M. Badger.....	Dillon.
A. M. Brailsford.....	Mullins.
F. L. Carpenter.....	Latta.
E. M. Dibble.....	Marion.
H. A. Edwards.....	Latta.
C. T. Ford.....	Mullins.
C. Henslee.....	Dillon.
A. D. Lewis.....	Nichols.
A. McIntyre.....	Marion.
J. G. Rogers.....	Poges Mill.
F. A. Smith.....	Mullins.
Z. G. Smith.....	Marion.
E. B. Utley.....	Marion.

MARLBORO.

(MARLBORO COUNTY MEDICAL SOCIETY.)

*Secretary, J. H. Reese, Tatum.*

W. J. Crosland.....	Bennettsville.
C. S. Evans.....	Clio.
J. A. Faison.....	Bennettsville.
D. Hamer.....	McColl.
J. A. Hamer.....	Clio.
J. L. Jordan.....	Bennettsville.
J. F. Kinney.....	Bennettsville.
C. R. May.....	Blenheim.
J. C. Moore.....	McColl.
C. D. Napier.....	Blenheim.
J. L. Napier.....	Blenheim.
W. M. Reedy.....	Clio.
J. H. Reese.....	Tatum.
A. S. Townsend.....	Bennettsville.
J. A. Woodley.....	Tatum.

OCONEE.

(OCONEE COUNTY MEDICAL SOCIETY.)

*Secretary, D. L. Smith, Newry.*

J. W. Bell.....	Walhalla.
E. C. Doyle.....	Seneca.
W. R. Doyle.....	Seneca.
E. A. Hines.....	Seneca.
J. H. Moore.....	Walhalla.
A. M. Redfern.....	Clemson.

— Rosser.....	Westminster.
B. F. Sloan.....	Walhalla.
D. L. Smith.....	Newry.
J. H. Stribling.....	Seneca.
C. M. Walker.....	Westminster.
J. M. Wickliffe.....	West Union.

PICKENS.

(PICKENS COUNTY MEDICAL SOCIETY.)

*Secretary, H. E. Russell, Easley.*

J. E. Allgood.....	Liberty.
J. L. Bolt.....	Pickens.
L. G. Clayton.....	Central.
R. J. Gilliland.....	Easley.
R. Kirksey.....	Pickens.
W. M. Long.....	Liberty.
L. O. Mauldin.....	Pickens.
L. F. Robinson.....	Dacusville.
J. O. Rosamond.....	Easley.
H. E. Russell.....	Easley.
W. A. Sheldon.....	Pickens.
W. A. Tripp.....	Easley.
E. B. Webb.....	Liberty.
C. N. Wyatt.....	Easley.

RICHLAND.

(COLUMBIA MEDICAL SOCIETY.)

*Secretary, Mary R. Baker, Columbia.*

E. C. L. Adams.....	Columbia.
Sarah C. Allan.....	Columbia.
J. W. Babcock.....	Columbia.
A. E. Boozer.....	Columbia.
Mary R. Baker.....	Columbia.
W. A. Boyd.....	Columbia.
J. H. Burkhalter.....	Columbia.
G. H. Bunch.....	Columbia.
Hubert Clator.....	Hopkins.
S. M. Deal.....	Columbia.
T. M. DuBose.....	Columbia.
S. B. Fishburne.....	Columbia.
R. W. Gibbs.....	Columbia.
H. H. Griffin.....	Columbia.
L. A. Griffith.....	Columbia.
LeGrand Guerry.....	Columbia.
Jane B. Guignard.....	Columbia.
S. E. Harmon.....	Columbia.
Henry Horlbeck.....	Columbia.
A. B. Knowlton.....	Columbia.
R. A. Lancaster.....	Columbia.
W. M. Lester.....	Columbia.
A. A. Madden.....	Columbia.
J. H. McIntosh.....	Columbia.
P. V. Mikell.....	Columbia.
R. L. Moore.....	Columbia.
L. B. Owens.....	Columbia.
Lindsay Peters.....	Columbia.
L. K. Philpot.....	Columbia.
D. S. Pope.....	Columbia.
H. W. Rice.....	Columbia.
A. E. Shaw.....	Columbia.
S. B. Sherard.....	Columbia.
B. W. Taylor (Hon.).....	Columbia.
J. L. Thompson.....	Columbia.
E. J. Wannamaker.....	Columbia.
J. J. Watson.....	Columbia.
William Weston.....	Columbia.
E. M. Whaley.....	Columbia.
C. F. Williams.....	Columbia.



## SALUDA.

(SALUDA COUNTY MEDICAL SOCIETY.)

*Secretary, J. D. Waters, Coleman.*

F. G. Asbill.....	Ridge Spring.
D. B. Frontis.....	Ridge Spring.
J. C. W. Kennerly .....	Mt. Willing.
J. J. Kirksey.....	Saluda.
S. M. Pitts.....	Big Creek.
L. J. Smith.....	Ridge Spring.
W. B. Smith.....	Wards.
G. L. Trotter.....	Fox.
J. D. Waters.....	Coleman.

## SPARTANBURG.

(SPARTANBURG COUNTY MEDICAL SOCIETY.)

*Secretary, O. W. Leonard, Spartanburg.*

A. M. Allen.....	Sp'bg, R.F.D. No. 4.
J. H. Allen.....	Spartanburg.
J. W. Allen.....	Enoree.
H. R. Black.....	Spartanburg.
L. J. Blake.....	Spartanburg.
J. R. Brown.....	Spartanburg.
G. A. Bunch.....	Spartanburg.
W. J. Chapman.....	Inman.
W. P. Coan.....	[R. F. D. No. 2.
	[R. F. D. No. 5.
A. D. Cudd.....	Spartanburg.
Geo. R. Dean.....	Spartanburg.
R. M. Dorsey.....	Spartanburg.
J. P. Dupree.....	Clifton.
J. Ed. Edwards.....	Spartanburg.
A. R. Fike.....	Spartanburg.
J. R. Gibson.....	Inman.
R. G. Hamilton.....	Converse.
Geo. W. Heinitsch.....	Spartanburg.
J. L. Jefferies.....	Spartanburg.
W. H. Kelly.....	Walnut Grove
W. L. Kirkpatrick.....	Pacolet.
S. T. D. Lancaster.....	Pauline.
J. M. Lanham.....	Woodruff, R.F.D.
O. W. Leonard.....	Spartanburg.
J. J. Lindsay.....	Spartanburg.
D. R. Norman.....	Fair Forest
H. E. McDowell.....	Spartanburg.
Geo. E. Means.....	Welford.
J. D. Orr.....	Spartanburg.
S. D. Parsons.....	Woodruff, R.F.D.
E. O. Posey.....	Woodruff, R.F.D.
F. L. Potts.....	Spartanburg.
Chas. E. Rogers.....	Duncans.
W. G. Sexton.....	Spartanburg.
W. A. Smith.....	Glendale.
H. B. Tate.....	Pacolet.
John O. Vernon.....	Welford.
Lee J. Wall.....	Spartanburg.
S. A. Wideman.....	Woodruff, R.F.D.
J. F. Williams.....	Roebuck.
G. DeFoix Wilson.....	Spartanburg.

## SUMTER.

(SUMTER COUNTY MEDICAL SOCIETY.)

*Secretary, Walter Cheyne, Sumter.*

S. C. Baker.....	Sumter.
Walter Cheyne .....	Sumter.
Archie China .....	Sumter.
F. M. Dwight.....	Wedgefield.
R. B. Furman.....	
J. A. Mood.....	Sumter.
C. P. Osteen.....	Sumter.
M. L. Parler.....	Wedgefield.

P. M. Salley.....	Pinewood.
J. C. Spann.....	Sumter.
H. M. Stuckey.....	Sumter.

## UNION.

(UNION COUNTY MEDICAL SOCIETY.)

*Secretary, Theo. Maddox, Union.*

C. W. Austell.....	Union.
R. R. Berry.....	Buffalo.
M. W. Chambers.....	Jonesville.
M. W. Culp.....	Union.
W. G. Fike.....	Union.
J. G. Goings.....	Union.
H. T. Hames.....	Jonesville.
J. H. Hamilton.....	Union.
J. T. Jeter.....	Santuc.
J. M. Lawson.....	Union.
Theo. Maddox .....	Union.
D. H. Montgomery.....	Union.
S. G. Sarratt.....	Union.
W. O. Southard.....	Jonesville.
C. Torrence .....	Union.

## YORK.

(YORK COUNTY MEDICAL SOCIETY.)

*Secretary, J. R. Miller, Rock Hill.*

Jno. I. Barron.....	Yorkville.
I. A. Bigger.....	Clover.
R. A. Bratton.....	Yorkville.
J. W. Campbell.....	Clover.
L. L. Campbell.....	Rock Hill.
T. R. Carothers.....	Rock Hill.
T. A. Crawford.....	Rock Hill.
T. N. Dulin.....	Clover.
W. W. Fennell.....	Rock Hill.
T. B. Hough.....	Tirza.
W. M. Love.....	McConnellsville.
J. E. Massey.....	Rock Hill.
J. E. Massey, Jr.....	Rock Hill.
J. D. McDowell.....	Yorkville.
B. N. Miller.....	Smyrna.
J. R. Miller.....	Rock Hill.
E. W. Pressley.....	Clover.
J. H. Saye.....	Sharon.
W. G. Stevens.....	Rock Hill.
M. J. Walker.....	Yorkville.
T. S. R. Ward.....	Hickory Grove.
W. G. White.....	Yorkville.

## HONORARY FELLOWS.

1870.....	F. L. Parker.....	Charleston.
1870.....	B. W. Taylor.....	Columbia.
1871.....	T. G. Simons.....	Charleston.
1872.....	J. C. Spann.....	Catchall.
1873.....	A. A. Moore.....	Camden.
1873.....	M. G. Salley.....	Pinewood.
1873.....	R. L. Brodie.....	Charleston.
1874.....	W. H. Nardin.....	Anderson.
1874.....	J. F. Pearce.....	Claussens.
1874.....	O. B. Mayer.....	Newberry.
1875.....	T. G. Croft.....	Aiken.
1875.....	Manning Simons .....	Charleston.

The following Counties have not yet affiliated:

Bamberg.	Georgetown.
Beaufort.	Horry.
Berkelev.	Lancaster.
Chesterfield.	Laurens.
Clarendon.	Newberry.
Darlington.	Orangeburg.
Edgefield.	Williamsburg.

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### South Carolina Medical Association.


Next Annual Meeting at Columbia, S. C.,  
April 18th, 1906.

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# THE JOURNAL

OF THE

SOUTH CAROLINA MEDICAL ASSOCIATION.

4 Vanderhorst Street, Charleston. S. C.

ROBERT WILSON, Jr.,  
Editor.T. P. WHALEY,  
Associate Editor.

C. P. AIMAR, Managing Editor.

ANNUAL SUBSCRIPTION, \$2.00.

THE JOURNAL is published monthly under the auspices of the South Carolina Medical Association. Members who do not receive their copies will please notify the Managing Editor at once. Secretaries of county societies are requested to send reports of their meetings, and items of news that may be of interest to the profession. Original articles are solicited. Articles should be type-written; and illustrations sent with articles will be printed at the expense of the writer. Reprints will be furnished at the rate of 75c. a page for a hundred copies.

All matter must be in the hands of the editor by the 10th of each month.

## EDITORIAL COMMENT.

### A CALL TO COUNTY SOCIETIES.

The Editors of the *Journal* have been very much disappointed at not receiving more frequent reports from County Societies which they had hoped would constitute an important and useful feature of the publication. From many we have never heard. Our county organizations do not seem to realize the great advantage of keeping in close touch with one another by means of such communications. There has been a great awakening.

We have some live and very active societies which are doing splendid work, but they will do better work and develop a stronger power under the stimulating influence of intercourse and discussion. Again, these live societies should feel it their duty to endeavor to encourage their more sluggish brethren to higher effort

and to kindle enthusiasm where interest and activity are low. Sometime ago we read in a daily paper an account of an enthusiastic meeting of the Pee Dee Medical Association held at Florence, but no report of this meeting was received by the *Journal*. This is not right. Oconee and Charleston want to know what Florence and Marlboro are doing, and they need the stimulus they will get from an account of Pee Dee enthusiasm.

Let every county society give us a monthly report of its proceedings, and let each with generous rivalry try to make the best showing. There is a vast amount of work to be done, but it needs an active and united profession, and no means should be neglected that may promote unity and increase our strength.

## CONCERNING INDECENT ADVERTISING.

It is good to read that in St. Louis a fine has been levied for indecent medical advertising, and that the next step will be the prosecution of the newspapers which insert such advertisements as being equally guilty under the ordinance. It is a pity that in our cities similar ordinances are not passed to purge our own newspapers of their filth. Every morning our leading papers treat us to such foul and noisome advertisements as "Tarrant's Extract of Cubebs and Capaiala in Capsules—The *tasteless, quick and thorough* cure for gonorrhoea, gleet, whites, etc." "Big G—Cures in 1 to 5 days—Guaranteed not to stricture—PREVENTS CONTAGION." An advertisement to treat successfully Bladder Diseases, Stricture, Varicocele, Specific Blood Poison (syphilis), Urinary Disorders—Juvens' Tablets for lost manhood, etc., ad nauseam. And these things are not relegated to some corner where only those interested may seek and find, but are often distributed among the news columns where they are forced upon the unwilling eyesight of everybody. The newspapers in St. Louis, it is said, have paid no attention to the interesting



conviction. This, if true, is not surprising. In these days of advanced civilization and refined culture money is a necessity, morals are not.

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#### A STATE HEALTH OFFICER.

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In his letter of transmissal the chairman of the Executive Committee of the State Board of Health gave the endorsement of the Board to the Governor's proposition to create the position of State Health Officer, and at the present session of the General Assembly a bill to this effect will be presented. It is proposed that this officer shall be secretary of the Executive Committee of the State Board of Health and its executive officer. It shall be his duty under the direction of the State Board of Health or its chairman to investigate reported outbreaks of communicable diseases and to employ needful suppressive measures. His jurisdiction shall extend to the quarantining of animals in cases of Hydrophobia and other animal diseases transmissible to man. The State Health Officer shall have his office at the state capital in order to be within easy reach of all parts of the state, and he shall be paid a salary of \$2,000. We believe that such an officer would afford valuable assistance in carrying out measures for the prevention and suppression of epidemic diseases, and we heartily commend the proposition. We would suggest that all county societies send to their respective representatives an endorsement of the bill and urge them to aid its passage.

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#### BENJAMIN WALTER TAYLOR, M. D.

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On Dec. 27, 1905, Dr. Benjamin Walter Taylor died in his home at Columbia, S. C. Having passed the psalmist's limit of three score and ten he has gone to his long home full of years and honors. Dr. Taylor was graduated from the South Carolina College in the class of '55, and three years later received his degree of Doctor of Medicine from the Medical

College of the State of S. C. After graduating he settled at Columbia to take up his life's work, but when the war broke out he offered his services to his state and was assigned, with the rank of assistant surgeon, to Fort Moultrie, where he served until the surrender of Fort Sumter. On the organization of the Hampton Legion he was appointed assistant surgeon in that body. When he was promoted to the rank of surgeon he was assigned to the 2nd South Carolina Cavalry, Hampton's Brigade. In the last year of the war he was promoted from the position of chief surgeon of division to that of medical director of cavalry corps, Army of Northern Virginia. After the close of the war Dr. Taylor returned to his old home, Columbia, with which he has been closely identified ever since.

Dr. Taylor has received many honors from his profession. In 1875 he was a delegate to the Medical Congress which met at Philadelphia. He has been president of the South Carolina Medical Association; chairman of the State Board of Health; president of the Board of Regents of the South Carolina Hospital for the Insane; medical director of Columbia Camp U. C. V.; he was a member of the American Medical Association; and of the Southern Surgical and Gynaecological Association. Twice, in 1875 and in 1896, was he president of the Richland Co. Medical Society, from which a few years ago he received a silver cup in recognition of his valuable services to his profession. But not only was he honored and respected by the members of his own profession, his long life consecrated to the service of all won for him universal love and confidence. "Well for him who leaves behind him a treasure of love, esteem, honor and admiration in the memory of men."

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#### FOURTH DISTRICT MEDICAL ASSOCIATION.

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On Monday, February 5th, there will be a meeting of all the doctors in the fourth Association District in the city of Greenville. The meeting will be called

to order at noon in the handsome new quarters of the Greenville County Medical Society, over Bruce & Doster's drug store on Main Street. This meeting will mark the formation of the Fourth District Association, comprising the counties of Anderson, Greenville, Oconee, Pickens, Spartanburg and Union. An interesting but brief program has been arranged, and a fine course dinner will be tendered at the leading hotel by the County Society to all the visiting physicians.

This district organization is to be entirely informal, and the plan is to have *no dues whatever*. An annual meeting will be held, the place of meeting to be in one of the counties of the district, and the small expense of entertaining will thus fall on the members of one county society once every six years.

Every doctor in the district is urged to attend, and is requested to notify Dr. J. W. Jervey, chairman committee, Greenville, S. C., of the intention to be present, as it is desirable to know about how many guests will be present.

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## ORIGINAL ARTICLES.

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### THE PATHOGENIC PROTOZOA.

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G. MCF. MOOD, M. D., CHARLESTON, S. C.

The Protozoa, though widely distributed, being found as parasites in nearly all classes of animals, have been satisfactorily proven the etiologic factors in but few pathologic processes. The extremely complex life cycle of many forms, some requiring an interchange of hosts, and their strict parasitism prevent the culture methods applicable to many lower organisms. The life history of many of this class of organisms is still obscure, or entirely unknown. There is, however, much reason for the belief that future investigations will show many of these obscure forms exciting factors in some of the serious infectious diseases whose etiology is still unknown. The protozoa are unicellular animal organ-

isms, varying in size from forms just visible to the naked eye to those requiring high magnification. They may be divided into the following four classes:

- I. Sarcodina, or Rhizopoda.
- II. Mastigophora.
- III. Sporozoa.
- IV. Infusoria.

#### I. THE SARCODINA OR RHIZOPODA.

In structure, these are the simplest of the Protozoa. The feature characteristic of this class is that its movements are caused by the throwing out of pseudopods, or false feet, from its body. These pseudopods result from protoplasmic activity, which enables the cell to protrude any portion of its body. These protrusions becoming fixed, the protoplasm of the cell slowly moves in a current into the protrusion, which is gradually enlarged by it until the entire cell protoplasm has changed to the new position, the cell wall being drawn up around it. This class feed by the same process of throwing pseudopods around particles to be incorporated. But one of the Rhizopoda is of interest to us, the "Amoeba Dysenterica," usually known as the "Amoeba Coli" (Lösch). This organism first discovered by Lösch, in the feces of persons suffering from tropic dysentery, is, when quiescent, a spheroidal cell, about  $\frac{5}{8}$  times the size of a red blood corpuscle. This shape varies with the activity of the organism. The protoplasm is granular, and usually contains large and small vacuoles, which appear as clear areas, distinctly outlined. The granules may not be evenly distributed through the protoplasm, but may be confined to one side of the cell, the rest looking homogeneous. Again, they may be grouped around the vacuoles. Imbedded in this protoplasm is a nucleus, rather large and granular, but not so conspicuous as the vacuoles.

It is almost impossible to detect this organism in cold feces, as it then assumes a spheric form, and all movement ceases. To detect them, they should be actively motile, and to have them thus, certain precautions are necessary, the chief of



which is to collect the feces in a warm vessel, and keep them warm until completion of microscopical examination. To do this, it is best that they be examined immediately on a warm slide on warm stage of microscope. If this is not handy, the feces may be kept warm by placing in a warm, tightly-corked bottle, which is immersed in warm water, or better, placed in the incubator, and may finally be examined, for a few minutes, on a warmed slide alone.

As the rectal mucus is most apt to contain the organisms, a drop of this is taken from the feces, or probably what is better a warmed rubber catheter, with several irregular holes cut in it, is introduced 5-6 in. into the rectum and withdrawn, when considerable pus, blood and mucus will be found adhering to the edges of the holes. This is more easily examined than when contaminated with feces. When examined thus, we find the amoebae in active motion, throwing out and retracting their pseudopods, and gradually changing their position. The amoeba is best studied with a small amount of light, and viewed with an oil immersion lens. The amoeba coli probably multiplies by fragmentation of the chromatin, somewhat like the protozoa of malaria, (this process will be discussed in connection with that organism, as we know more about it in this relation), but direct nuclear division may occur.

*The Avenues of Infection* by this organism are not known, but it probably gains entrance through the mouth, and mostly in polluted drinking water. As the vital resistance of the amoeba coli outside of the intestine is slight, they dying in a few hours even when placed under the most favorable conditions, and moreover, as it has never been found unassociated with dysentery, nor has it been cultivated artificially,\* the degree of transmissibility from one person to another is probably limited. They are probably more often taken up from surrounding nature;

but whether they persist here in some as yet unknown vegetative intermediate stage, or in an intermediate host, or whether after leaving the body they develop permanent forms, is as yet unknown. Nor has it been satisfactorily proven to be the cause of the disease. Cats and dogs have developed typical amoebic dysentery after rectal injections of stools containing amoebae, and one cat, after feeding upon infected feces; in all cases the amoebae being recovered in large numbers. These experiments cannot be accepted as proof positive when we consider the immense number of bacteria, introduced along with the feces, any of which could have acted as a causative factor. The organism is found, however, in all cases of tropical dysentery, and disappears from the intestine with the disappearance of the disease. Tropical dysentery is rather rarely seen by us, and then mostly in cases acquired elsewhere (tropical countries). It is of most interest to us now on account of its prevalence in our newly acquired territory, and its introduction here by returning soldiers.

## II. MASTIGOPHORA.

The protozoa of this class are characterized by the possession of one or more motile flagella.

The *Cercomonas Intestinalis* is a small oval or pear shaped organism, possessing one terminal flagellum, and, when alive, is seen to be quite active. It has been observed in evacuations of persons suffering from cholera, typhoid fever, and diarrhoea.

The *Trichomonas Vaginalis* is also an oval or pear shaped organism with a cluster of flagella at one end, and an undulating membrane upon the side. This organism is occasionally found in vaginal exudate.

These organisms, though not infrequently observed, have never been proven pathogenic. The most interesting organism of this class, and one that is pathogenic, is the trypanosome. Organisms of this type have been repeatedly observed in the blood of both wild and domestic animals for a number of years, but their importance was not appreciated

\*Since this article went to press the author has learned that artificial culture of amoeba coli in association with ani bacterium have been made.

until Sir David Bruce, working in South Africa, proved conclusively that nagana or tsetse fly disease, which is so fatal a disease among cattle and horses there and among the Andes (*mal de coderas*), in South America, is due to a trypanosome (which now bears his name), and moreover that the disease is spread by a tsetse fly, which acts as the intermediate host.

In human medicine its connection with *sleeping sickness* of western and central Africa, principally, is of greatest interest to us. Up to Nov., 1902, this disease was supposed by most investigators to be due to *Filaria Perstans* (Manson), though considered by some to be due to various animal and vegetable parasites. The presence of the latter can be easily explained, as entering through ever present bed sores. This supposition was based exclusively upon the frequency with which it was met in persons suffering from sleeping sickness, in spite of the fact, that it was found just as frequently in those exhibiting no symptoms of the disease; and it has been later shown that this filaria occurs in regions entirely free from sleeping sickness. In November, 1902, Castellani, working in Uganda, reported having found a trypanosome in the cerebro-spinal fluid of several—20 out of 34—patients with sleeping sickness, and raised the point whether there might not be some connection between this parasite and the disease. In March, 1903, an English expedition (Commission from Royal Society of London) arrived in Uganda, and at once grasping the importance of Castellani's observations set to work in conjunction with him.

The cerebro-spinal fluid from several hundred persons suffering with sleeping sickness was examined, and a trypanosome found in each instance. Moreover, this trypanosome was found in the cerebro-spinal fluid of *no* case not suffering with sleeping sickness. Later the organism was found in the peripheral circulation. Now, as to the mode of infection: After continuous researches, suggested by Bruce's discoveries, it was noticed that

the distribution of sleeping sickness—the epidemics of which are peculiarly local—coincides almost exactly with that of a tsetse fly, the "*Glossina Palpalis*;" moreover the disease is not found in districts free of this fly; which was at once suggested as the carrier of the disease. The truth of this opinion was soon confirmed. Tsetse flies caught, in the contaminated district, were placed in a cage with monkeys, which harbored no trypanosoma. All of these monkeys soon showed trypanosoma in their blood. Moreover, a monkey was inoculated in the spinal canal with cerebro-spinal fluid from a case of sleeping sickness, and five weeks afterwards died, with all the symptoms of sleeping sickness, and organisms were found in large numbers in cerebro-spinal fluid. Later this organism was found in the peripheral circulation of persons not affected with sleeping sickness, though it was observed that some of these later developed symptoms of the disease. About the same time Dutton published a description of a fever of an undulating type observed among natives of western Africa, due also due to a trypanosome—"Trypanosoma Gambiense" (Forde).

The organisms in the two conditions are identical, and it is now agreed that the disease described by Dutton is simply the stage of invasion, so to speak, of sleeping sickness, a great number of these patients dying finally of sleeping sickness. Moreover, the disease produced in monkeys is the same when inoculated with either organism. The disease may then be divided into two stages, the first in which there is an intermittent and irregular temperature, and in which the patient is able to go around fairly well. During this stage the trypanosoma can be found in the peripheral circulation, but not in the cerebro-spinal fluid (Trypanosomiasis). In the second stage the true symptoms of the disease are seen, when the organism can be found in both the circulation and the cerebro-spinal fluid. How the organism gets from the peripheral circulation into the spinal canal is not known. The disease, however, is transmitted from diseased to healthy persons by a tsetse fly,



*Glossina Palpalis*, and probably by it alone.

This disease, though rarely observed in white people, is of great importance in Africa, in one province in the central part of which it has caused 30,000 deaths in three years.

If I may be allowed to digress a little from the subject, I will mention a few symptoms of this peculiar disease. It has along incubation period, sometimes lasting three years, with an average of a few months. The first symptom noted is a general decrease in the patient's normal activity; there is headache and vague ephemeral pains, usually localized in upper portion of the thorax. The patient's walk becomes unsteady, and speech slow, hesitating and difficult. There is usually a very characteristic quivering of the tongue, which is sometimes accompanied by trembling of the hands. Pyrexia sets in, and is from the start, of a remittant type with wide oscillation, often reaching 102-103° F in the evening, and falling to normal by morning. The pulse is quickened, but its tension is lowered. Loss of flesh proceeds rapidly, intellectual torpor increases more and more, and finally leads to continued somnolence.

Muscular asthenia is gradually followed by complete loss of strength, and the patient can no longer help himself. The sphincters become relaxed, the temperature gradually falls below normal, the pulse becomes abnormally slow, somnolence merges into coma, more and more complete, the patient finally succumbing in from four to eight months after the beginning of the disease.

The parasites are found by making fresh blood preparations, as in malaria, or by examining a drop of spinal fluid obtained as in meningitis, and are easily seen, wriggling across the microscopic field, pushing aside the blood-corpuscles. In length, the organism varies from about twice to four times the diameter of a red blood corpuscle. It is spindle shaped, both ends tapering gracefully. One end is provided with a long flagellum—a continuation of an undulating membrane, attached for nearly the entire length of one

side of the body. The body itself is granular, and contains a nucleus near its anterior extremity, a centrosome near its posterior extremity, and a contractile vacuole somewhere in its protoplasm. It can be easily stained with a weak solution of Methylene-blue, or by any of the methods used in staining the plasmodium of malaria. It is always found in the plasma, never having been observed in the corpuscles. They are best observed with an oil-immersion objective. This organism multiplies by longitudinal or transverse division, sometimes by rosette formation, the segments gradually growing to mature organisms; they probably have a sexual cycle of development, as yet unknown.

### III. SPOROZOA.

Sporozoa are animal parasites living at some period of their life cycle in the cells of their hosts, and are especially characterized by their reproduction through encystment and spore formation. They are found as parasites in nearly all classes of animals.

On account of their strict parasitism and complex life cycles, the life history of some of the sporozoa is but imperfectly known, and of many, entirely unknown. There are several interesting members of this class, and future investigations will probably add to it many more. One, which is of great interest and extreme importance, and one about which most is known, is the *Plasmodium Malariae* (Laveran).

Our knowledge of this organism has been perfected by:

1. The discovery of the parasite in human blood by Laveran.
2. The discovery of its developmental cycle in man (asexual) by Golgi.
3. The discovery of its developmental cycle in the *Anopheles* mosquito (sexual) by Ross.
4. The discovery of the function of the flagellate bodies, by MacCollum.

Three distinct types of malarial organisms have been demonstrated within human erythrocytes.

1. The Tertian parasite (*Plasmodium Vivax*).

2. The Quartan parasite (*Plasmodium Malariae*).

3. The Estivo-Autumnal parasite (*Leverania Malariae*).

These organisms obtain entrance to the human system as "blasts" or "embryos," through the puncture made by the proboscis of an infected mosquito, (genus anopheles), escaping with the lubricating salivary secretion. These blasts, by some attractive force, first adhere to the red blood corpuscles, into which they subsequently enter.

The Tertian parasite appears in the erythrocytes, first as small hyaline bodies, having ameboid movement, and assuming ring, cross, or star shapes.

The rings are less regular than those of the estivo-autumnal organism. As the parasite grows, there appears about its periphery, pigment granules, of a dark brown color, produced by destructive changes in the corpuscle, upon which the contained parasite preys. With this, the red corpuscle swells, and becomes paler. Eventually the parasite almost fills the corpuscle, the pigment increasing to a considerable amount, and moving actively with the protoplasmic currents. Segmentation now begins, occurring just prior to the paroxysm. The pigment granules collect toward the center and become motionless, and radiate striations are formed in the organism, giving it a rosette-like figure, of twelve (12) to twenty (20) parts; each part or segment, gradually becoming a small spherule, spore or merozoite. The corpuscle now bursts, and the little spherules being set free, begin their cycle of development by entering new red corpuscles, as minute plasmodia. With the spherules, the pigment granules are set free, and being taken up and deposited by phagocytes in the viscera and deeper layers of the skin, produce the peculiar "bronzing" so often found associated with the disease.

This cycle of development requires 48 hours. The Quartan parasite is similar to the tertian, differing in that the pig-

ment granules are distinctly darker, coarser and less abundant; moreover, they are usually but slightly motile. Slight ameboid movements are often discernible, but they gradually cease (in about 64 hrs.), the parasite assuming a round or oval shape. This parasite is smaller than the tertian, occupying only a portion of the red cell which is below normal in size. Another peculiarity is that the red cells are not markedly decolorized, but on the contrary, their color may be intensified, or changed to a greenish or brassy tinge.

In about 72 hours segmentation occurs. Six (6) to ten (10) segments, and finally spherules being formed. Pigmented intra-cellular bodies are likewise found in the blood in Estivo-Autumnal fever, but which differ markedly from the tertian and quartan parasites. It is smaller, frequently occurring as rather regular ring-shaped, highly refractive bodies, usually containing little pigment which in turn displays slight if any movement. The organism occupies only about  $\frac{1}{3}$  to  $\frac{1}{4}$  of the containing corpuscle, which may be irregular, shrunk or crenated, but is not decolorized, often exhibiting a brassy tint. Although centrally placed pigment may be seen, segmentation does not occur in the peripheral circulation, occurring in the viscera.

The duration of its cycle of development is indefinite. The cycles of development thus far described, represents the asexual cycle, or intra-corporeal development and multiplication of the malarial organism which serves to reproduce the parasite indefinitely in the blood of a diseased person.

Now to consider the sexual or extra-corporeal cycle of development, occurring in the stomachs of mosquitoes (anopheles). It has been observed that certain forms of the malarial parasite take no part in the multiplication just described, and which, outside of the body, undergo changes which have suggested another method of reproduction. These forms are large round or oval hyaline or pigmented extracorporeal bodies found



in tertian and quartan fevers, and crescentic oval and spheric bodies, found in estivo-autumnal fevers. The crescentic bodies found in estivo-autumnal fever, are rarely found within the red cells; sometimes, however, the remains of the cell can be seen as a delicate line, extending between the horns of the crescent. The typical crescent is a highly refractile body, somewhat larger than a red blood corpuscle, having rounded ends, and containing fine granules and rods of pigment, which is usually motionless and centrally collected, but may be aggregated in one of the horns.

Crescents rarely occur in tertian fever.

The oval and spheric bodies are smaller than the crescent, but exhibit similar features. Analogous to these, are the large hyaline and pigmented bodies, found in tertian and quartan fever.

These bodies, after escaping from their hosts, the red blood corpuscles, develop rapidly, and in the tertian form, may obtain the size of a polymorphonuclear leucocyte. The pigmented bodies, containing motile pigment in their centres, are smaller than the hyaline forms. If blood containing these parasites is kept moist, and examined after standing 15 or 20 minutes, the cytoplasm of the granular organism is seen suddenly to become tumultuous, and to extend elongate filaments with energetic lashing movements. These filaments (Flagella), each containing some of the nuclear substance of the parent cell, remain attached for a few minutes, then break loose, and swim actively with a serpentine movement between the red corpuscles, and if not followed up and watched closely, are soon lost sight of. For a long time these were supposed to be some kind of degeneration of the parasite, until MacCallum, in following one of the flagella of *Halteridium daneleuskyi*, found that it advanced towards one of the large hyaline bodies, and ultimately formed a symbiosis with it. The same fact was subsequently determined for the tertian malarial parasite. This symbiosis is undoubtedly a form of sexual fertilization. The large

hyaline bodies (females) are therefore described as macrogametes, the flagellate pigmented forms (males) as microgametocytes, the flagella as microgametes, and the purpose of these extracorporeal bodies made clear. The female parasite thus fertilized is called a zygote or zygocyte. Ross found that this sexual symbiosis, somewhat analogous to the fertilization of the ovum by the spermatozoon, took place in the stomach of the mosquito, and having with much labor determined that the anopheles was the proper host of the parasite, discovered that the zygocyte then invades the wall of the stomach or mid-intestine of the mosquito, and lodging there, segments and develops a distinct capsule. The cystic structure so formed (oocyst) contains numerous minute rods or sporozoites, formed by cytoplasmic segmentation. This oocyst projects into the coelom cavity of the mosquito, and finally rupturing, discharges into it, the contained sporozoites or blasts, which are carried thence to different portions of the body, and eventually to the salivary glands, from which they are introduced with the saliva, into any person subsequently stung by the insect.

Thus the extracorporeal or sexual cycle of development of the parasite is completed, and the perpetuation of the organism provided for.

Malarial fever is acquired, so far as we at present know, wholly from the bites of infected mosquitoes of the genus anopheles, and it is only when these exist, that there is danger of infection. The bite of the mosquito, is, in itself, as harmless as that of the common culex, except when it has become infected by feeding upon some human being suffering from malaria. Even after it has become thus infected, it is incapable of conveying the disease until such time has elapsed that the blasts make their appearance in the saliva, which, according to temperature, varies from 8 to 14 days. Once thus infected, however, a mosquito remains dangerous during the remainder of its life, and can infect any number of human beings upon whom it may feed. A sin-

gle infected human being, similarly, is capable of infecting any number of mosquitoes which may feed upon him, and leave in a place formerly free of malaria, a host of mosquitoes, capable of spreading the disease.

The extermination of the anopheles mosquito is all but a hopeless task, as they multiply rapidly, have short embryonic lives, and are capable of living and breeding in very small quantities of water. The destruction of the parasite in infected human beings, by the systematic use of quinine, will, by preventing the infection of new mosquitoes, limit the spread of the disease. In a district where the disease abounds we can hope to escape infection only by protecting ourselves from infected mosquitoes by proper screening, and from the malarial parasite by the use of quinine. The diagnosis of the disease by the finding of the parasite in the blood, is, with a little practice, not difficult. An essential is that the blood smear should be made as thin as possible, so that the red cells will not overlap and pile upon each other but be separate, with a space between, and should be made from perfectly freshly drawn blood, as distorted and cremated corpuscles are unsatisfactory. Films thus made dry almost immediately, and after being fixed and stained should be viewed with a  $1/12$  oil immersion objective.

Another sporozoon of some interest, is the *Piroplasma Hominis*, only lately found to be the cause of mountain spotted fever. This parasite is devoid of pigment and has an asexual reproduction, probably effected by binary division, and a sexual phase of development which takes place in various species of tick, from which, through its bite, the organism gains entrance to the human system. Its intracorporeal existence occurs in its host, the red blood cell. It is not known whether, as in the *Piroplasma Bigeminum*, the parasite of Texas fever in cattle, the organism during its developmental stages in the tick is able to pass into the eggs of the latter, and infect the embryos.

#### IV. INFUSORIA.

These are the most highly differentiated of the protozoa. They have numerous cilia, which may persist throughout life or be replaced by suctoria. They reproduce chiefly by fusion or budding. Only one of this class is of interest.

The *Balantidium Coli* or *Paramoecium Coli*, differs from the mastigophora, in that its entire body is covered with fine cilia, thickest just around the mouth orifice, situated at one end which is usually more pointed than the other. It is an oval organism, measuring about 1 mm. in its greatest diameter; contains a pale nucleus, and from two to four vesicles. Small particles of starch, droplets of fat, and miscellaneous food particles, are sometimes detected within its cytoplasm. By means of its cilia, it moves with a rapid darting motion.

This organism has been known to affect man in various portions of Europe, Asia and North America, in whom it caused persistent diarrhoea with ulcerations of the stomach and intestines, with profound anemia. Fatal cases of dysentery, due to infection with this organism, have been reported. Infection with the *balantidium coli* is supposed to occur from the dejecta of swine, in whose intestines the organism is said to be habitually present.

The technique necessary for its detection in feces is identical with that described for the detection of the amoeba.

In the last few years, a great deal of interesting and important work has been done, with the object of discovering if possible the specific etiologic factor of yellow fever, and its modes and avenues of infection, so that the spread of the disease can be more effectually prevented. Although thus far, the organism has eluded detection, its intermediate host has been proven conclusively to be a mosquito, (genus *Stegomyia*), thus furnishing the key to the prevention of infection, and thus limiting the disease. Future investigations will probably show the cause of this disease to be a protozoon organism, with a life history somewhat



similar to that of the plasmodium malariae.

Our knowledge of the infectiousness of yellow fever is quite definite. The patient can convey the disease to the mosquito only during the first three days of sickness, (not during the incubation period, or after the 3rd day of the disease).

Again, the mosquito after feeding upon a yellow fever patient during these first three days is not itself capable of transmitting the disease for from 12 to 18 days, depending upon temperature. They are capable, however, of infecting non-immunes, probably for the remainder of their lives. Moreover, the incubation period in the human subject has been accurately determined, varying from 41 hours to 5 days, 17 hours.

In 1903, the myxococcidium Stegomyia, was, by its discoverers, advanced as the cause of the disease, but was subsequently demonstrated to be a wild yeast cell.

In 1905, Pothier, Hume, Watson and Couret, working in New Orleans, reported finding certain previously undescribed cells in the blood of yellow fever patients, found only during the first three days of the disease, except in one instance, when they were found on the fourth day.

These cells were likewise found in the stomachs of recently infected mosquitoes.

Future investigations will decide the significance of these findings.

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#### THE DIAGNOSIS OF DISEASE RESULTANT UPON LESIONS IN THE VASCULAR SYSTEM.\*

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WM. P. CORNELL, M. D.,

CHARLESTON, S. C.

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Gentlemen:—In presenting this paper for your discussion my object is to emphasize the importance of using all the means and methods at our command, and especially the stethoscope, in arriving at

a conclusion as to the character and extent of injury present in the vascular system.

The surgeon who through carelessness fails to provide sufficient or suitable instruments for an operation, and so subjects his patient to needless and harmful prolongation of time on the table, does or should feel the responsibilities of his neglect—in like manner the physician should appreciate that the stethoscope as well as the thermometer are instruments without which he cannot hope to do justice to his patient. How often have we been satisfied to simply place our ear to a patient's chest, and, listening through his or her clothing, (including corsets in the case of a woman), and hearing no murmur, hastily conclude that the heart is normal? And yet the most serious damage may be present and be impossible of recognition by means of auscultation alone, even if a stethoscope has been used on the naked chest.

Who would attempt to diagnose an incipient tubercular lesion in an apex with his naked ear, and especially through the patient's clothing? And yet heart affections at times present more difficulties in diagnosis than the most incipient tubercular lesion in that we have no temperature to help out, no microscopical possibilities and no history of exposure to fall back on, and must depend solely on our powers of observation and knowledge of physiology.

Just as in the management of a case presenting cardiac disease the therapeutics is directed in main to relieving conditions existing at a distance from the heart, so should our attention in making a diagnosis be particularly devoted to ascertaining what secondary effects have resulted from a leakage or obstruction at a certain valve.

The diagnosis that such or such a valve is affected is the least important part of the final conclusion arrived at as to the patient's present condition and future prosperity.

In order to avoid a lengthy paper I will as briefly as possible discuss the most essential points to be considered in the di-

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\* Read before the Medical Society of S. C. of Charleston Co., Jan. 15, 1906.

agnosis of a case suffering from the effects of a heart lesion.

To begin with, a patient should be questioned closely regarding slight dyspnoea on exertion, slight cough, tightness of the shoes, changes in the daily output of urine, evidences of indigestion, menstrual disorders, palpitation, and attacks of dizziness. Most of these being the result, in these cases, of passive congestion of the various viscera with lowering of their functioning powers.

Inspection: Next the chest should be bared sufficiently to at least observe the entire precordial area; and the cardiac impulse is studied as to its position, extent of area, and rapidity; remembering that in adults it is normally in the 5th space, inside of left nipple line, of an area of about 1 sq. inch; and that in children it is high and in the aged low in position. A misplaced impulse always means an abnormal condition, either of the heart or of surrounding viscera, unless we have a condition of dextrocardia or situs inversus. All cardiac diseases are not associated with displaced apex beat. Excluding all causes outside of the vascular system, we may say that an impulse found lower than normal and to the left indicates enlargement of the left ventricle, or else aneurism of the arch displacing the heart downward, whereas enlargement of the right ventricle will cause the impulse to be to the left but *not downward*.

We must remember also that the left border of the heart is from  $\frac{1}{2}$  to  $\frac{3}{4}$  inch further to the left than the visible or palpable impulse.

Visible epigastric pulsation, seen beside the xiphoid, and formerly thought to be due to the right ventricle enlargement, is now known to occur normally, and also to be due to the low heart of arterio-sclerosis.

In states of anaemia, owing to retractions of the overlying tongue of lung, we get a visible pulsation to the left of the sternum in the second and third spaces.

A wavy impulse travelling over several rib-spaces usually denotes a dilated right heart.

Visible pulsation in the veins of the neck, if systolic, means tricuspid regurgitation.

Systolic flushing with diastolic pallor of the surface capillaries, as under the nails, denotes usually either aortic regurgitation or lowered arterial tension. Violent throbbing of carotids or temporals is seen in pure aortic regurgitation, and at times in great hypertrophy of left ventricle, also in arterio-sclerosis, especially of arch.

*Palpation* tells us whether we have a strong heart action as in hypertrophy, by the powerful, heaving beat, or the weak heart-action of dilation with its diffuse slap; again, mitral stenosis gives us a sudden tap, whereas aortic stenosis gives us a slow thrust.

Thrills of mitral or of aortic stenosis are distinctive and their possible presence alone should call for palpation being made.

*Percussion* alone is of little service, but in some cases, taken in conjunction with the other methods of examining, is invaluable, (i. e., in cases of ill-defined mitral stenosis, where we would probably get the negative evidence of non-enlargement of the left ventricle, or again in suspected aneurismal enlargements, dullness over upper sternum is strongly suggestive.

*Auscultation* intelligently and properly performed is probably our most valuable measure in discerning these conditions but the mere determining of the presence or absence of a valvular murmur is probably the *least* important point in our search.

The careful and minute study of the several valve-closure sounds is highly important as indicative of the blood pressure in the system beyond and because it is this very raising or lowering of the blood pressure which works most of the damage to the system at large.

The cause of the normal first-sound of the heart is not definitely known, but the most common belief is that two factors are present in its production, 1st, the contraction of the heart muscle itself, and, 2nd, the sudden taughtening of the mitral curtains. This is important, in that we shall see later on that in certain condi-



tions of the heart muscle this sound becomes purely valvular, like that of the 2nd sound of the heart which is caused solely by the closure of the aortic and pulmonary valves acting together.

When listening at the apex, the 1st sound is longer and duller, booming and more intense than the 2nd, which is shorter, less intense and snapping. The second sound at the base is still more snappy and intense.

If in listening at the apex we get apparent lengthening and increase in intensity of the 1st sound, we know that the left ventricle is over-acting (acting more powerfully) and, throwing out ordinary exertion or excitement, we think 1st of dilatation of the left ventricle and next of hypertrophy of left ventricle. Mitral stenosis causes the first sound to appear like a very sharp slap.

If, instead of a long, intense 1st sound we get a short and weakened one, we presume that the muscle of the ventricle is weakened which would account for the loss of the muscle element of the sound, and only the taughtening of the mitral cusps produces the sound, which is short and sharp in character.

This condition is found in the weak heart of continued fevers, in fatty heart, in emphysema and in pericardial effusions.

If in listening *at the base*, we get apparent *accentuation of the 2nd aortic sound*, and we must remember that this is normally louder than the pulmonic 2nd, in all over 60 years of age, and in most over 40. It indicates increased arterial tension beyond the valve, and produces directly increased work for the left ventricle, and so points indirectly to *Hypertrophy* of this organ, because, any organ which is called upon to produce more work, will, so long as its nutrition is unimpaired, manifest increased power for work, by hypertrophying. This accentuation of the 2nd aortic sound is also seen in diseases of the aorta as aneurism or dilatation.

Weakening of the 2nd aortic sound indicates either great relaxation of the peripheral resistance, or else, and more

commonly, less blood thrown into the aorta, so that the recoil is not so strong, as seen in mitral disease, especially stenosis, also aortic stenosis, espec. if pure, or again in any weakened condition of the left ventricle, as from myo-carditis or heart failure (pneumonia).

Changes in the rhythm of the heart's action in certain conditions give very valuable data for prognosis, and enable us to try and combat such condition as is evidenced by the special disturbance. For instance, the tick tack rhythm heard in the typhoid state means incomplete diastole and would probably call for digitalis, to strengthen the weakened heart, or better perhaps, glonoin to lower, or adrenalin to raise peripheral arterial pressure, and so hasten the circulation and lessen the congestion.

*Gallop Rhythm* means short diastole with doubling of the 1st or 2nd sound, and when permanent indicates grave cardiac weakness.

*Doubling of the 2nd or basic sound* indicates increased pressure beyond and delayed systole of the ventricle whose valve sound is the last; owing to the resistance, the ventricle takes a little longer to empty itself.

In mitral stenosis, an important diagnostic sign is doubling of the 2nd sound, as heard at the apex, its cause possibly being due to the congested state of the pulmonary circulation and its consequent delaying of the systole of the right ventricle; or else, the left ventricle having less blood, empties itself more rapidly, or possibly both conditions exist at the one time.

This is supposition on my part, as the text books examined state that the cause for this doubling is unknown.

We now come to the discussion of cardiac murmurs, the recognition of which as such I have said makes one of the least important of our sum total of diagnostic data.

The most important evidence we seek is the condition of the heart as a whole, its state of nutrition especially, and then what degree of compensation exists, and in what condition are the general system-

ic arteries, for no matter how splendid the condition of the heart itself may be, if the arteries are diseased we know that the heart will ever after be overworked, and its failure will be inevitable—"a man is as old as his arteries."

The localization of a murmur isn't always an easy matter, and at times is impossible. The first point in their study is to determine their rhythm, i. e., systolic or diastolic.

There can be only two murmurs at each valve, and one must be systolic and the other diastolic. All murmurs are caused by obstruction to the flow of the blood through the valve, therefore if we hear a murmur at a given valve on systole when we know that normally no blood should go through that valve with systole, we conclude that regurgitation is taking place: for example, mitral regurgitation.

Again, if we hear a murmur at a given valve on systole, and know that normally the blood does go through that valve with systole, there must be an obstruction, because the blood makes no sound while passing through a normal valve: for example, aortic stenosis.

These principles hold true with diastolic murmurs, and if our knowledge of the physiology of the heart, and of the normal direction of the blood current with systole and diastole is not at fault, we should be able in simple uncomplicated cases to readily determine the rhythm of a murmur.

*Next*, we determine the *seat*, or the valve-area at which the murmur is produced, by its *intensity* or loudness, and by its *direction of transmission*, and if we remember that the blood causes and carries the murmur, the transmission should not, in simple cases, be difficult to determine.

So we see that all murmurs have three points by which they are distinguished: rhythm, seat, and transmission. A murmur systolic in rhythm, seat at the aortic area, and transmission upward with the blood current, cannot mean any other valve lesion than aortic stenosis.

The louder a murmur the better

pleased we should be, because it denotes a strong heart propelling a strong current of blood, except in cases of acute valvulitis before compensation is established, in which case, increasing loudness may mean progressive lesion.

Therefore, the gradual disappearance of a murmur known to be due to an organic lesion is a grave sign, and its return to loudness is a hopeful prognostic.

Again, we are often called to patients in whom we know a valvular lesion exists and find their heart acting so weakly that no murmur is produced; but in a few days, if the patient lies quietly in bed, the heart will become stronger and the murmur audible.

Therefore, the most important point about the loudness of a murmur is its increase or decrease in loudness while under observation, and not its loudness at any one time.

As to their quality: Soft blowing murmurs usually are heard in regurgitation, while harsh, churning murmurs usually mean stenosis.

Musical murmurs are very rarely heard except in organic lesions.

If the valve-closure sound is wholly displaced by a murmur, it usually denotes a great amount of destruction to the valve, and therefore is a bad prognostic, in that greater effort at compensation must be made.

Effect of position, exercise, and respiration upon murmurs:

Some systolic murmurs which are inaudible while sitting or standing, may be easily heard in the recumbent posture.

Some pre-systolic murmurs which are easily heard while sitting or standing, may disappear on lying down.

Diastolic murmurs are not much affected by change of position, but are usually best heard in the upright posture.

Murmurs inaudible at rest, and brought out by exercise, are usually from a slight lesion.

Organic murmurs are usually heard loudest at the end of expiration.

We now come to the discussion of the so-called Functional Murmurs, or those



in which no organic lesion can be found to account for their production.

These are also spoken of as Haemic, and as Accidental Murmurs.

Their cause is a temporary or permanent dilatation of the Conus Arteriosus, or else pressure or suction exerted upon the overlapping lung margins by the heart contractions.

The recognition of haemic murmurs is much simplified if we can remember their eight characteristics, which are:

1st. Systolic in rhythm (99%).

2nd. Site at pulmonic area in second left space, though at times their point of maximum intensity may be at the apex or aortic areas.

3rd. In quality they are almost always soft and blowing (and remember that a systolic basic organic murmur must mean stenosis, and stenotic murmurs are usually harsh and loud, and may be musical.)

4th. Functional murmurs are not transmitted outside of the precordial area.

5th. They are not associated with secondary changes in the heart, such as enlargement, or accentuation of the pulmonic second sound. Again, it is important to remember in this connection, that in chlorosis, owing to retraction of the tongue of lung that normally overlaps the pulmonic area, the pulmonic valve-closure sound may be accentuated.

6th. Functional murmurs are usually associated with anaemia, though they may be present without blood changes, and very often are absent in the pernicious forms of anaemia.

7th. They are louder at end of inspiration.

8th. They are very evanescent in character: that is, they may appear after any violent exertion, such as a boat race, and last only a very few days.

The so called Cardio-Respiratory murmur is very often heard, and in a hasty examination could easily lead to a grave mistake in diagnosis.

It is caused by the heart beating against overlying lung tissue, and displacing some of the contained air.

This murmur may be heard in almost any region, but is especially common un-

der the left clavicle, at the angle of the left scapula and at the apex.

It is almost always systolic in rhythm and especially loud at the end of inspiration, and is markedly affected by getting the patient to exhale and then hold his breath, when it should cease.

As mentioned, valvular lesions are of two kinds, stenotic and regurgitant, and it is of importance to recognize which of these is present, because they produce different secondary effects in the various chambers of the heart.

A stenosis always and invariably means that organic change which is irreparable has taken place, and therefore tells us that the heart will always have to work in compensation.

A regurgitation, on the other hand, may be perfectly curable and the heart may regain its normal functioning powers and cease to work in compensation, and thereby regain its reserve-force.

For example, in typhoid fever, prolonged toxæmia may so weaken the heart muscle that its chambers finally dilate, and the muscles to which the chordæ tendinæ are attached become stretched to allow the mitral cusps to fly back into the left auricle, or the dilatation may be so great as to produce with it dilatation of the mitral ring, so that the valve cannot completely close the opening. In these cases, if the patient recovers from the typhoid, and remains at rest long enough, the heart muscle may regain its tone, the papillary muscles become shortened back to normal, and the mitral ring regains its normal size, and so the regurgitation becomes checked, and finally the heart returns to normal.

By recognizing such a condition we can reassure our patient and gain his cheerful consent to perhaps a prolonged stay in bed, and the effect upon his convalescence of the knowledge that his heart condition is curable must be very different than if he is simply told that his heart has become seriously affected, and that if he moves about it may suddenly stop beating.

Again, the earlier diagnosis between stenosis and regurgitation is made the

better we can control the degree of enlargement and the consequent loss of the reserve energy of the heart necessary to the establishment of compensation.

In stenosis we have an organic lesion producing obstruction to the flow of blood through the diseased valve (say the mitral), and we know that almost always a stenotic lesion is very slowly produced.

Now, the first effect of such a lesion is that the left auricle has to work more powerfully in order to empty itself through its narrowed outlet, and it becomes hypertrophied, and because the lesion is slowly produced, and the orifice of outlet slowly narrowed, the auricle has plenty of time to become hypertrophied, and so of itself may thoroughly compensate for years; and we know that women, in whom this lesion is especially common, owing to their comparatively quiet lives as regards physical exercise live many years without ever consulting a physician; and all because of the gradual onset of the lesion and the abundance of time allowed the left auricle in which to compensate, so that they have not suffered with any of the usual symptoms of marked congestion of the lungs and brain.

I have said that this class of women do not consult the physician, but they do very frequently go to the gynaecologist complaining of disturbances of their menstrual periods; and they will usually be found to be rather thin than otherwise, with evidences of malnutrition, and of a sallow color.

The cause of these symptoms is to be found in the fact that, owing to the obstruction at the mitral orifice, the left auricle could not completely empty itself into the left ventricle, and therefore the left ventricle did not have quite a normal quantity of blood to send forth into the general circulation for the maintenance of the nutrition of the body at large. Hence these slight and gradually produced distant signs which should always call for a careful examination of the heart as well as of the pelvic regions.

On the other hand, we meet in its incipency a case of mitral regurgitation, and recognize at once the absolute impor-

tance of immediate treatment, the object of which is to obtain compensation, if possible, without the development of dilatation, and this can only be accomplished by absolute rest in the recumbent position.

Dilatation, and not hypertrophy, of the left auricle is the first effect of a mitral regurgitation, because immediately after the auricle contracts, the ventricular contraction begins, and in doing so forces a quantity of blood back into the auricle, which is at the same time receiving its normal supply from the lungs through the pulmonary veins. Now, during this inrush of blood from two sources, the auricle is relaxed, and therefore the more easily over distended or stretched, just as in boxing, a light blow on the body of a man off his balance will floor him, and here we have the auricle off its balance or relaxed so that it cannot resist the distending influence of the inrushing blood, and by the time its systole commences its fibres are already over stretched, and still they have to contract with more than normal force to eject the more than normal amount of contents. The inevitable result is still further stretching of the muscle fibres and consequent dilatation of the chambre.

But here the reserve force asserts itself and the auricular walls hypertrophy and become stronger, in order to properly eject the contents.

During the time that this dilatation or hypertrophy is taking place, there is a damming back into the pulmonary veins and congestion in the lungs, which congestion, besides causing such symptoms as cough and dyspnoea, especially on exertion, which makes the left ventricle contract more frequently and forcibly, and so increases the congestion in the lung, increases the work of the right ventricle which hypertrophies, and, as stated in the beginning of this paper, this hypertrophy is recognized by the accentuation of the second pulmonic sound.

From the foregoing, you can see how in mitral regurgitation an early diagnosis and the immediate institution of treatment can prevent to a great measure the serious secondary results.

The first effect of rest is to lessen the



number of cardiac contractions 40,000 a day; this lengthens the long pause of the heart rhythm and allows the blood in the left auricle more time to enter the left ventricle; the emptying of the auricle allows more of the dammed up pulmonary circulation to drain into the auricle, and this lessening of the congestion of the lungs relieves the strain on the right ventricle, which in turn will stop in its process of becoming hypertrophied.

This hypertrophy is what takes place in untreated cases, but in very early cases, as immediately after an infectious disease, as an acute rheumatism, or diphtheria, we can, by keeping the patients in bed, limit the amount of dilatation in the left auricle and allow it alone to become hypertrophied, which is the whole aim of our treatment. We cannot treat the lesion in the valve itself, unless it be by lessening any irritating effect which might ensue from the passage of a strong blood current over the inflamed area.

The symptoms and signs of mitral stenosis and regurgitation due to secondary changes behind the lesion are essentially the same and due to the same causes, and differ only in the earliness of their appearance, being usually delayed in stenosis, maybe for years, and the first sign is accentuation of the 2nd pulmonic sound, without which the diagnosis of a mitral murmur due to organic lesion should not generally be made.

In front of the lesion we have the signs varying in the two conditions. In stenosis the left ventricle has less work to do, owing to less blood entering through the stenosed orifice, therefore it does not enlarge, and, if anything, atrophies somewhat, and so we will not have the apex beat misplaced until the right ventricle becomes enlarged, and then it will be displaced to the left, but not downward. Whereas, in regurgitation, the left ventricle has to work harder in order to make up for the lost or regurgitating stream, and also because the auricle, when it does contract, forces more blood than normal into the relaxed ventricle which increases its work, and so the ventricle becomes hypertrophied, and the apex beat is seen to

be misplaced both outward and downward, but especially downward.

In lesions at the aortic valve, or in fact any valve, the secondary changes in the various heart cavities and bodily viscera are due to the same causes as already outlined, and as long as sufficient hypertrophy exists to maintain compensation the patient will not complain, and treatment, other than hygienic and supportive, is uncalled for.

If called to a case in which compensation is well established, we will usually be able to tell which circulation is impeded: namely, if the right ventricle is the one enlarged, it points to resistance in the pulmonary circulation, and we will hear the accentuation of the pulmonic second sound, whereas, if the left ventricle is hypertrophied, it indicates resistance to the general arterial circulation, and we will get accentuation of the aortic second sound.

Some authors state that the diagnosis of chronic nephritis should not be made unless on examining the heart we get accentuated aortic second sound with some evidences of hypertrophy of the left ventricle, and a pulse of continued high tension.

Finally, and it may be years, in most cases the heart, handicapped as it is by leakage, or obstruction at its valve or valves, becomes worn out by its efforts to maintain the circulation.

The usual causes of this failure seem to be either dilatation and weakening of the heart walls, or else malnutrition of the heart muscle from disease of the coronary arteries.

But whatever the cause, the result of broken compensation is venous stosis, in the form of oedema or dropsy of various organs.

This dropsy is seen first in the legs with left ventricular failure, and in the lungs, manifested by dyspnoea, cyanosis, cough and hemoptysis, if the right ventricle has failed.

Other symptoms demanding an examination of the heart and all due to the same cause, venous stasis, are ascites, hemorrhoids, enlarged spleen, chronic in-

digestion, pallor, headaches, scanty urine, enlarged liver, and very often varicose veins, and as before mentioned, disturbances of menstruation.

As to the differential diagnosis of the various valvular lesions, I will consider but one that of aortic stenosis, which frequently may be confused with affections such as atheroma, aneurism or dilatation of the arch of the aorta; both on palpation may give a thrill at the second right space; both may, on auscultation, give a systolic murmur over the aortic-valve area which is transmitted with the blood current upward into the vessels of the neck, and both conditions will produce hypertrophy of the left ventricle. But the pulse, and the character of the aortic second sound are distinctive in each.

In aortic-stenosis, owing to the narrowed opening, the left ventricle takes longer to empty itself and so sends a slow stream of blood into the aorta: this gives the characteristic pulse of stenosis, namely a slowed pulse, which rises gradually under the finger, and which is small.

Also, because of the slowness and smallness of the current thrown into the aorta, the recoil against the aortic valve is weak, and we get therefore an aortic second sound of diminished intensity.

In disease of the arch, on the other hand, the pulse is apt to be hard and bounding; *hard*, because general arteriosclerosis is now thought to be associated with a similar disease of the aortic arch, and *bounding*, because the enlarged ventricle having no obstruction at its outlet, the aortic valve sends a strong wave of blood with each contraction into the general circulation. Again, because of this strong wave being thrown into the aorta, the recoil is correspondingly strong, and we get a markedly accentuated aortic-valve-closure sound.

One more point and I have finished. I believe that it is stated that an aortic regurgitant murmur is transmitted into the vessels of the limbs; this does not seem rational to me, and I have never been able to find it so. Duroziez's sign of aortic regurgitation is obtained by producing a constriction in the wall of the femoral

artery by pressing the bell of the stethoscope down upon the vessel, when a systolic as well as a diastolic murmur will be heard, the latter being due to the regurgitating blood stream meeting with the obstruction caused by the stethoscope. But this murmur is not the sound produced at the aortic valve by blood several feet in front of that part of the current causing the murmur.

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#### APPENDICITIS.\*

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A. B. BAKER, M. D., CHARLESTON, S. C.

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The literature on this subject is so extensive that to do justice to it, I fear, would make this paper too long. There is no disease of the present age which concerns the laity as well as the physician more than this, which is largely due, I expect, to its sudden onset, its treacherous nature, and often even its fatal termination. I quote from M. H. Richardson, who said, "I am firmly convinced that appendicitis is the most important acute abdominal disease of the present time, and that, excluding certain zymotic diseases, it is the cause of more deaths than any other abdominal disease." Before going into the more practical feature of the subject I wish to mention briefly the history of appendicitis. It was not until the year 1824 that the vermiform appendix received recognition as an organ susceptible to disease. Sixty years elapsed before it was clearly and generally understood. Not until 1886 was this inflammatory affection known to be so fatal in its termination. The treatment of an appendicitis by means of celiotomy thus assumed importance from the moment the true nature of the disease began to be understood, and the frequent opening of the abdominal cavity supplied in its turn opportunities for the investigation of the disease in all its stages, which have heretofore been lacking.

*Etiology:* The predisposing causes may

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\* Read before the Charleston Medical Club, July 6, 1905.



be local or general. I will only mention the most common factors uniting to call forth an attack of an appendicitis. Edebohls claims that the floating kidney is quite a frequent agent in producing this disease. He believes a kidney acts as an exciting cause indirectly through disturbances to the circulation owing to compression of the superior mesenteric vessels. C. Beck, on the other hand, believes that the kidney acts as a direct cause by the pressure on the appendix itself.

W. P. Manton states that in his experience the movable kidney is the most frequent cause of chronic appendicitis.

C. P. Noble, in 100 operations in cases of movable kidneys, did not observe six cases of appendicitis. Appendicitis is a disease distinctly of early life. It is not rare in children, but is most common between the ages of 10 and 30 years. After this period there is a rapid decrease in the number of cases, although it is by no means rare even in advanced life. The analysis of a large number of cases demonstrates the greater liability of the male sex to appendicitis. The combined statistics of several authors give a percentage of 75 in males and 25 in females. The negro race, apparently, from statistics, is comparatively exempt from this disease. S. C. Briggs, of Nashville, Tenn., out of several hundred operations for appendicitis could recall only one in a negro. H. J. Inge, of Mobile, Alabama, out of 146 operations had but one in a negro, and by inquiry among other physicians found its occurrence in this race equally rare in their experience.

C. B. Noble, of Atlanta, has never operated on a negro for appendicitis. E. L. Hill, of Montgomery, Alabama, ("in the black belt"), says that only four cases had occurred among the negroes of that city with a population of 9,000, and found that the physician who had been consulting for a number of years at Booker Washington's school where there were about 1,400 students, did not remember to have ever seen a case there. The physician in charge of 800 prisoners at one of the Alabama coal mines states that appendicitis is unknown among them. The

explanation given for this relative exemption of the negro is that his diet is simple. They take a great deal more outdoor exercise. Disorders of digestion have the most important influence in determining an acute attack of appendicitis. In many cases there is a history of chronic constipation. Sometimes an acute attack comes on shortly after a hearty meal of unsuitable food. Sometimes diarrhoea with symptoms of acute enterocolitis may precede an attack of appendicitis.

Trauma is a direct factor in the causation of some cases of appendicitis more often than has been supposed. Indirect injury, such as straining and heavy lifting, is a more common cause than a direct blow. Foreign bodies and concretions are also exciting causes.

A few years ago the origin of appendicitis was frequently thought to be due to foreign bodies: namely, the seeds of various fruits, etc. Now there is a general recognition that foreign bodies are comparatively rare, and that concretions although present in a considerable number of cases, probably play an infrequent causative role in the disease. Recently considerable attention has been directed to the relation existing between intestinal parasites and appendicitis. Lumbricoid worms and other varieties have been found in the appendix.

*Symptoms:* Any attempt at describing the symptomatology of appendicitis must be preceded by the statement that any or even most of its characteristic symptoms may be absent in the beginning of any given case, or even through its entire course. Symptoms of the most pronounced character accompany certain lesions in one case, and fail to appear in another.

S. W. Gay characterizes appendicitis as the most treacherous of known diseases, insidious in its manifestations, uncertain in its career, and liable to sudden changes which at any moment may put the patient in condition of extreme peril. It is a matter of common experience to find a mild attack which is apparently subsiding develop symptoms of the gravest

significance, while in other cases the most grave symptoms are sometimes followed by speedy recovery.

Acute appendicitis may have a sudden onset, or it may be insidious in character being ushered in with symptoms of moderate severity which steadily grow worse, or it may possibly exhibit occasional remission. In a number of cases a feeling of general malaise precedes the onset of the attack. The early symptoms may include pain, tenderness, rigidity, muscle-spasm, nausea, vomiting and constitutional disturbances; distension and tumor may also be present. The time at which these symptoms appear, however, is variable, and some of them may never occur at all. The most constant, most characteristic, and the most important symptoms of all are pain and rigidity. Pain, tenderness and rigidity are properly called the cardinal symptoms of appendicitis, and they demand the first and most careful consideration. There are, however, other symptoms which generally occur and which may have a positive value. The most important of these are gastrointestinal disturbance, elevation of temperature, and altered pulse rate. The general constitutional symptoms also are often of great significance.

We find the pulse is of greater importance than the temperature as an indication of the condition of the patient and as a guide to prognosis, and more especially the relation of the pulse rate to the temperature. A very rapid pulse is always a grave symptom, and a rapid pulse out of proportion to the amount of fever usually foretells a fatal termination.

As regards chronic appendicitis, it may follow an acute attack or the symptoms may be chronic from the beginning. The chronic relapsing form in which the patient is never well is subject to more or less acute exacerbations. Constipation is one of the most constant symptoms of chronic appendicitis, and is often most obstinate. With it there are frequently more or less marked dyspeptic symptoms, especially after indulging in certain articles of food.

*Diagnosis:* Kelly says that appendicitis is by far the most common in-

flammatory disease of the abdomen, especially in men under 30, and in children of both sexes. When the cardinal symptoms present themselves, viz, sudden acute abdominal pain, tenderness on pressure over or near McBurney's point, and localized muscular rigidity, the diagnosis of appendicitis is justified in the majority of cases. Other symptoms, such as nausea and vomiting, constipation or diarrhoea, elevation of temperature and acceleration of pulse make the diagnosis more sure, and the presence of a tumor puts it beyond doubt.

If after 24 hours the patient seems to be getting worse instead of better complications may usually be expected; if after 36 or 48 hours there is a continuation of high fever and a corresponding rapid pulse suppuration or general infection is to be expected. A rapidly increasing pulse rate, especially when out of proportion to the degree of fever is one of the most urgent symptoms of seriousness.

*Differential Diagnosis:* The most important sources of error are the acute visceral affections, especially those which result in peritonitis. From cases of renal and gall stone colic, twisting of an ovarian pedicle, torsion of a movable kidney, general peritonitis and intestinal obstruction the most experienced surgeon finds it at times difficult to make a diagnosis.

In perforations of gastro-intestinal ulcers or of other viscera, the symptoms are most commonly referred to the umbilical or epigastric regions, and in the absence of the history pointing to these regions the differential diagnosis is often impossible without an explorative operation.

Lead colic also may be mistaken for appendicitis and *vice versa*. Tubercular peritonitis, both in the chronic and acute forms, may simulate appendicitis. Floating kidney has been mistaken for appendicitis, and several instances have been recorded in which the true condition was only discovered at operation. It is therefore essential in the presence of floating kidney to definitely exclude the presence of appendicitis. Renal calculus may produce symptoms closely simulating acute or chronic appendicitis.

Brewer, of N. Y., refers to three cases



in which a diagnosis was made of appendicitis which proved to be cases of uretal and renal calculi.

Every surgeon of wide experience has had cases in which it was exceedingly difficult and often impossible without an exploratory section to differentiate between appendicitis and acute or chronic diseases of the gall bladder and its ducts.

As regards gynecological diseases, the pelvic organs in women form the most important class of cases liable to be mistaken for appendicitis and *vice versa*.

Pneumonia and pleurisy, particularly in children, may be ushered in with acute abdominal symptoms, and operations have been performed for supposed appendicitis.

This paper would not be complete without reference to leucocytosis as an aid in diagnosing appendicitis. In certain obscure abdominal conditions the leucocyte count may be of great assistance in diagnosing this disease. A count of 20,000 or more in a case exhibiting very mild signs and symptoms is not infrequent. This enables the surgeons to estimate the gravity of the patient's condition, when without its aid both surgeon and patient might be misled. A low leucocyte count on the other hand must not mislead the surgeon. Our present knowledge does not furnish any definite rules for the use of the leucocyte count in diagnosis, and the following general rules should be applied only after taking into account the history, symptoms, physical signs and all other factors usually considered in each individual case.

In acute appendicitis without complications it may be generally stated that the leucocyte count increases with the severity of the disease, and that increasing leucocytosis indicates an increasing inflammation. The contrary, however, does not always hold true. A high leucocyte count in the first 24 hours excites grave apprehension, for it is suggestive of a severe inflammation with perhaps a gangrenous appendix. A leucocyte count above 15,000 occurring at the end of an attack, when the local symptoms have almost disappeared generally indicates lo-

calized pus. When local abscess formation occurs in the early stages the leucocyte count as a rule is very high, above 15,000. With a chronic abscess the count is usually low, but it often fluctuates with exacerbations of the local symptoms.

The leucocyte count is a most valuable aid in making a differential diagnosis where doubt rests between acute appendicitis and typhoid fever, at its onset with a temporary focussing of the symptoms in the right iliac fossa. The leucocyte count in typhoid fever is always low, the highest point being from 8,000 to 10,000. The count never mounts up but tends to descend rapidly.

Before proceeding to consider the question of operation, let us consider briefly what remedies may be applied in any case until the services of a surgeon can be secured as well as the best measures of relief in cases which do not require operation.

The first step which is of prime importance in the treatment is to put the patient to bed, keep him quiet, and regulate his diet. Ice should be applied locally over the right iliac fossa. Some surgeons are still loud in their praises of the advantages accruing from free purgation, especially with saline cathartics. The opinion of most, however, is in favor of keeping the bowels entirely at rest, in order to check peristalsis. When using opium it must be constantly borne in mind that large doses have the disadvantage of obscuring the clinical picture, and concealing the real condition of the patient. It relieves the pain and sensitiveness only in an artificial way.

Dr. Worcester says there is only one logical treatment of the disease, viz., "excision of the diseased organ as soon as the diagnosis is made."

Kelly says that no case of appendicitis where an operation was necessary was ever operated on too soon, and when the decision to operate is made no consideration however plausible should be admitted as a reason for necessary delay.

Operations are classified according to the stage of the disease at which they are performed. There are four, viz., early

operations, performed at the very outset; intermediate operations performed from the second to the fifth day; late operations performed after sufficient time has elapsed for the formation of an abscess; and interval operations performed between the attacks.

The ideal time for operation for appendicitis is within the first few hours, and not later than the first 24, when the organ can readily be detached from the surrounding structures, and before the formation of an exudation or of an abscess with adhesions among the bowels. It must always be remembered with the present condition of our knowledge how rapid the progress of an appendicitis will be.

In one case of Finney's a hospital nurse was seized with her first attack of pain shortly after coming on duty in the morning, and the operation performed within three hours after the apparent onset showed the appendix gangrenous on one side and ready to perforate. Some of the advantages of early operation may be summed up as follows: It is safest because it can never be foreseen which cases may go on to suppuration, and which may not. And again fatal complications may arise at any moment absolutely without warning. The operation is far more easily done which lessens the possibility of evil results, and the patient is spared days of suffering, and is blessed with a rapid recovery instead of a protracted convalescence of weeks or months. Again the liability to recurrent attacks is obviated. An early operation obviates the risk of hernia which is so common in suppurative cases.

Halsey says "if a case is on the rise, operate, if it is on the fall you may wait. If a case is falling, but not fast enough one is prone to operate to relieve anxiety."

Finney says, "The surgeon is himself never so unhappy as when watching an appendicitis which has not been operated upon."

Abbe declares "when the diagnosis is made is the time to operate, for there is no case of appendicitis that can be trusted no matter how simple the symptoms seem to be."

Richardson also finds himself more and more inclined to operate at any stage of disease, no matter when it is detected.

Kelly says "to wait the 24 hours period often worked detrimentally by conveying the impression that no serious lesion or extension of the disease can take place within the first 24 hours, when there is abundant evidence to the contrary. If we must fix a date, it would be better to fix a two hour rule, and call two hours a safe period."

*Incisions.*—It may be laid down as a general rule that the appendix may be reached in all cases where a liberal incision is made anywhere in the right lower portion of the abdomen. The conditions necessitating operations must influence the choice of incisions. A number of different incisions have been employed by surgeons of ability and experience, viz., the median incision which was employed in all the earliest operations for the removal of the appendix, the vertical incision, Fowler's oblique incision, Roux's oblique incision, McBurney's, or the grid-iron, the incision in the semi-lunar line, Morris' short incision, Edebohl's lumbar incision, etc.

My method is to use McBurney's incision when no pus is present. The advantage of this incision, is that the patient can be permitted to get up on the eighth or ninth day, and leave the institution on the tenth day.

With an experience of sixty-five cases permitted to go home at this early date I have not met with any evil results such as hernia, etc.

The care of the stump has much to do with the safety of the operation and the good results obtained. A number of improved methods for removal of the appendix in simple uncomplicated cases are now in use. Many of these operations, though different in detail, may be classified in the following groups:

1. Ligation, excision and sterilization with stump projecting.
2. Ligation, excision and sterilization with depression of stump.
3. Inversion of stump.
4. Inversion of the entire unopened appendix.



5. Amputation flush with the cecum.
6. Amputation by means of the cautery.

My experience has largely been with the "Inversion of the stump" method. This appeals to me in that it is easily and quickly done and there are no raw surfaces left exposed to form adhesions, etc.

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## COUNTY NEWS.

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### Greenville.

The Greenville Co. Med. Society held its annual meeting on Dec. 4th, when the following officers were chosen for the ensuing year.

President, Dr. C. C. Jones; vice-president, Dr. C. T. J. Giles; secretary, Dr. J. Adams Hayne; treasurer, Dr. G. H. Bottum. Dr. Joseph B. Earle was elected member of the Board of Censors.

Over twenty members were present and a most satisfactory paper on "Diphtheria" was read by Dr. J. Adams Hayne, which was followed by a spirited discussion.

Dr. J. Wilkinson Jervey introduced a resolution relative to the prosecution of "quacks" and unlicensed doctors, and something will be done at once to rid the county of its many troubles in this line.

Steps were also taken to more firmly bind together the physicians of the upper counties of South Carolina. An invitation will be sent to the various county societies to meet in Greenville in February, and it is hoped that regular meetings of the same character can be arranged for the future.

If so, they will be held in different places in rotation.

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### Greenwood.

The Greenwood Co. Medical Society met on Dec. 4th, with a full attendance. The following officers were elected for the coming year:

President, John Lyon; first vice-president, Willie T. Jones; second vice-president, W. P. Barratt; secretary and treasurer, Dr. J. B. Hughey.

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### Marboro.

The Annual meeting of the Malboro County Medical Society was held at Bennettsville on the 19th inst. Drs. J. L. Napier, Faison, Jordan, Moore, Kinney, Crosland, D. Hamer, Townsend, Reedy and Reese were present.

The following officers were re-elected for 1906: President, Dr. J. F. Kinney, Bennettsville; vice-president, Dr. W. M. Reedy, Clio; secretary and treasurer, J. H. Reese, Tatum.

Drs. J. A. Faison, A. S. Townsend and W. J. Crosland were appointed committee on Public Health and Legislation.

After adjournment, the Society dined in a body at the hotel.

### Spartanburg.

The regular monthly meeting of the Spartanburg Co. Medical Association was held on Dec. 22nd, 1905. Papers were read by Dr. J. F. Williams on "Broncho-Pneumonia," and Dr. Hamilton on "Acute Glossitis." Both papers brought forth much discussion.

Officers for the ensuing year were elected as follows:

President, Dr. J. H. Allen; vice-president, Dr. W. J. Chapman; treasurer, Dr. J. L. Jeffries; secretary, Dr. O. W. Leonard.

The retiring president, Dr. J. O. Vernon, and Dr. J. E. Edwards, were appointed to prepare papers for the regular meeting in January, 1906.

A very pleasant incident of the meeting was the presentation of a handsome and costly silver service to Dr. O. W. Leonard as a token of appreciation of his devoted services as secretary. The presentation was made by Dr. F. L. Potts on behalf of the Society.

Dr. Potts said: "Mr. President and gentlemen of the Spartanburg County Medical Society. It is perhaps known to every member of this society that but few men are qualified to make a good secretary. Hence it follows that the medical profession has a very small percentage of its number to offer for this important position, but I am glad to say that this organization is an exception and has among its members one who is capable of performing this function for any kind of organization, as good perhaps as any of our brethren of the legal profession. No doubt our present secretary deserves more credit for the present flourishing condition of our association than anyone else; he has labored long and faithfully; he has shown signs of enthusiasm in every meeting, and his suggestions have made our meetings most pleasant and profitable, and to him the honor is due. You know, gentlemen that this society would be the very best in South Carolina if Dr. Leonard could successfully infuse some of his enthusiasm to each member—the same enthusiasm that he clearly manifests at every meeting. Gentlemen, he is a good member, a good secretary, and I assure you he is a most excellent physician. At the last meeting of the Spartanburg County Medical Society, in the temporary absence of our secretary, a motion was made and unanimously carried that we in some way show our appreciation to Dr. Leonard for his faithful and efficient performance of duty. To you, Dr. Leonard, in behalf of the Spartanburg Medical Society, I present this token of our appreciation, which only partially expresses our gratitude to you for services faithfully rendered, and with its giving we individually and collectively wish for you that continued success which your ability and skill deserve."

Dr. Leonard was deeply moved by such marked evidence of his associates' good-will and esteem; and made a very feeling response.

The Society is in a very flourishing condition, and the meetings are well attended. It has next to the largest membership of any County in the State, and efforts are being made to get every reputable, legally qualified physician in the County to join.

Dr. O. W. Leonard has been appointed a member of the National Auxiliary Congressional Committee of the American Medical Association to

serve in and for the County of Spartanburg for the year 1906.

Dr. T. E. Mott, resident of Spartanburg and the oldest member of the society, is seriously ill.

### MARRIAGES.

On Wednesday, Dec. 27th, 1905, at Edgefield, S. C., Dr. John Gibson Edwards to Miss Ellamays Allen.

### A GREAT WORK.

#### WHAT A COUNTY SOCIETY MAY DO.

The following letter from one of the leading surgeons of Indiana contains so much of interest to county societies, indicating what may be done in any section where as many as three or four wide-awake men can be gotten together, that we are glad to put it before the profession. "What one man has done, other men can do."

VALPARAISO, IND., Dec. 21, 1905.

DR. J. N. McCORMACK, Chairman Committee on Organization, Bowling Green, Ky.

DEAR DOCTOR:—Your letter asking me to elaborate our plan of Post Graduate work here, with the view that such an account may be used in inducing other medical societies to do likewise has been received.

I am greatly pleased to have the privilege to do this, not only for your personal gratification, but for the reason that I am confident that it will redound to the very great credit of such societies as deem it wise to adopt our plan, as well as to the individual members. It will enable them to do better and more efficient work for the public as a whole, and aid each individual physician in rendering the best possible service to the unfortunate sick.

Our work was begun two years ago by getting every physician interested in becoming more familiar with scientific and practical knowledge which would be an advantage to him at the bedside and which would broaden him as a physician. With this end in view, we rented a room, formed a club, and endeavored in every way to appeal to and build up the social, scientific, and material spirit and welfare of the profession. From every point of view I desire to report that we have been eminently successful.

In carrying out this plan we divided our work in such a way that each physician was required to act as a teacher of some special subject, and all the others took their places as students once more. Anatomy and Surgery was assigned to one, Physiology and Practice to another, and so on through the list of subjects—one fundamental and one practical branch to each teacher. Our

meetings were held twice a week, regular lessons were assigned, and we were expected to be present and give one hour's time to the recitation and study of such subjects as were assigned to that evening. In this way we were enabled not only to exchange individual views as to what we believed, but could always have some good medical authority to place us right if it was found that we were wrong. This plan proved very desirable and we soon learned that the teacher of the topic derived far greater benefit from his course, for the reason that he was required to study more to hold his ground, often against the combined opinion of his class.

After going along in this way for a time it became apparent that our faculty should be changed from time to time, in order that the teachers should become proficient in more than one subject. I desire to report to you that we found this most satisfactory, and that it has resulted in marked improvement in the attainments of every member of our profession, which means of course of the profession as a whole.

The social feature of our plan has done as much, if not more, for the good of the profession, as the scientific work. I am now able to say that we have no one in this country not on the ject. I desire to report to you that we found this condition is because they actually desire to be friendly.

In addition we have kept up our regular society meetings, always with increased interest, and although ours is not one of the large counties, I feel safe in saying that we have one of the best, if not the best, society in the State of Indiana, and we are resolved to go on and make it still better.

In connection with this work it did not take us long to determine that, in consideration of the increase in the cost of living in recent years, we were not being adequately paid for our services, and we concluded that it was only just that the fees should be increased one-half. In order that this might be uniform we all signed the schedule definitely fixing the price of services for both day and night and had this published. It went into effect without a single ripple and has been strictly maintained. I have never heard a complaint on the part of the public or of the agreement being violated by any member. In fact, the public seems to understand the necessity for the change, largely for the reason that it knew we were making an heroic effort to give the people better service. The results have been that our incomes have been increased by one-half, and that night work has been reduced to a minimum, giving us the evenings for post graduate work and to spend with our families. While we have not accomplished all that we set out to do, we have certainly made rapid progress, and are not to stop or falter until our ideals are attained.

Probably this very crude plan might be greatly elaborated and improved, but it has worked so well, and given such universal satisfaction here that I am sure none of us would be willing to disturb our present satisfactory condition.

Should you be able to use what we have done as an incentive for others, or to elaborate it for the promotion of medical organization, you will have the very best wishes of every member of our profession in doing so. With personal best wishes,

I am most sincerely yours,

DAVID J. LORING, M. D.



## NOTES AND REVIEWS.

## PRACTICE OF MEDICINE AND CLINICAL MEDICINE.

JOHN L. DAWSON, M. D.

## ALBUMINURIA IN NEPHRITIS AND BRIGHT'S DISEASE.

Dr. Alfred Stegel, of Philadelphia, in an article, "Albuminuria in Nephritis and Bright's Disease," in the *Journal of the American Medical Association* for Jan'y. 6th, says:

" \* \* Albuminuria is an extremely common occurrence in various general diseases, and that, though it may in a sense indicate an inflammatory condition of the kidney, such inflammation or nephritis may be of merely pathologic rather than of clinical significance, unless the albumen is considerable in amount and more or less constant in occurrence. The nature of the accompanying tube casts must not be relied on too greatly to determine the seriousness of the renal lesion, and in particular the presence of an occasional hyaline cast or even the frequent occurrence of such must not be regarded with too much apprehension. The modern method of centrifugation and the consequent examination of quite fresh urine increases the likelihood of our finding casts, and there is often difficulty in distinguishing between the insignificant cylindroid of the mildest grades of renal irritation and the definite hyaline cast of more dreaded disease. Even the latter, however, is so frequent in cases of arterio sclerosis, cardiac disease, hepatic disease, jaundice and gouty affections without serious renal disease that its significance is more or less trivial, unless general clinical conditions accentuate the importance of its presence. I do not wish to convey the wrong impression that I estimate lightly the importance of urinary examination; far from it. But I know from much experience that a trace of albumin is too often magnified in importance in the physician's mind, and that the clinical conditions as a whole are not sufficiently considered. Above all things it is important in cases of suspected renal disease that the urine be repeatedly examined and its constant or fluctuating condition be taken into account.

## FEVER DURING MENSTRUATION AN EARLY SIGN OF TUBERCULOSIS.

Franck announced four years ago that a rise in temperature preceding or during menstruation is a strong presumptive sign of a morbid process somewhere in the body. It points especially to tuberculosis, and if the woman is anaemic and thin with a tendency to sweat and to catch cold readily, the physician will do well to inaugurate anti-tuberculosis treatment or to recommend a sanatorium, super-feeding or a course of cinnamic acid or iron and arsenic. He is convinced that the normal limit of temperature is 37.5 C. (99.5 F.), measured in the rectum, and that even a fraction of a degree above this is fever. Sabourin and Kraus have also recently pointed out the importance of fever during menstruation

as an early sign of tuberculosis. Measured in the rectum a fraction of a degree above normal may be due to the hyperemia of some inflammatory affection in the adnexa, but as such can be excluded, the assumption is in favor of tuberculosis.—*Berliner Klinische Wochenschrift*, Berlin.

## HABITUS PHTHISCUS AND TUBERCULOUS DYSPEPSIA.

Stiller has found that the floating tenth rib, which he long ago proclaimed to be a sign of the asthenic habitus, is also a sign of a consumptive tendency. This kind of body supplies a predisposition to tuberculosis as well as to nervous dyspepsia. The individual whose build stamps him as a candidate for tuberculosis is also a candidate for nervous dyspepsia. This explains why tuberculosis is complicated with dyspepsia in from 70 to 90 per cent. of all cases. He has found that the degree of movability and the extent of the defect in the tenth rib is an index of the extent of the dyspepsia and nervousness. In extreme degrees, the ninth rib may be movable also, and the eleventh and twelfth ribs may move much more freely than common. He has observed a number of cases in which apparently healthy individuals sank into a condition of severe dyspepsia, neurasthenia and emaciation in consequence of some trivial stomach or intestinal trouble—in one instance a tapeworm. They lost rapidly from forty to sixty pounds or more, and years were required to regain their former weight. Signs of gastropnoxis or nephropnoxis developed in most of them. Some constitutional disease or latent cancer seemed probable, but the rib stigma showed that the individual was hereditarily burdened with a tendency to dyspepsia and nutritional disturbances. Circumstances had been so favorable hitherto that he had kept at the highest limit until some accident upset him. In such cases there must be not only a lack of stability in the digestive, but also in the assimilating organs, probably due to participation of the intestinal sympathetic system in the asthenia of the central nervous system. This serious tendency is revealed solely and alone, he claims, by the rib stigma in an otherwise robust physical development.—*Berliner Klinische Wochenschrift*, Berlin.

## MATERIA MEDICA AND THERAPEUTICS.

J. L. NAPIER, M. D.

## ERYSIPELAS TREATED BY INJECTIONS OF ANTISTREPTOCOCCUS SERUM.

In the *Medical Record* of March 4, 1905. Ayer reaches the following conclusions:

1. That the administration of antistreptococcus serum shortens considerably the course of an uncomplicated attack of erysipelas.
2. That it tends to inhibit extension of the disease.
3. That it has a strikingly beneficial effect upon the general condition of the patient, reducing the temperature, pain, and discomfort incidental to the disease.

4. That it rapidly reduces the pathological leucocytosis.

5. That it prevents or suppresses febrile albuminuria.

6. That its use is attended with no danger, even in large doses.

7. That the only disagreeable symptom referable to the serum observed by the writer is a transient eruption which occasionally occurs at the site of the injection.

8. That the efficacy of the serum treatment is in direct ratio to the length of time which has elapsed between the onset of the disease and the first injection of serum.—*Therapeutic Gazette*, June, 1905.

#### THE MORNING DOSE OF SALINE

For the majority of people past middle life, and especially for those who suffer from fermentive indigestion, particularly of the lower bowels, as so many do, I want to emphasize the importance of the morning toilet, or rather of flushing of the bowel with a well diluted, non-irritating saline. Its action is first to unload the congested capillaries of the mucosa, and then to sweep out the accumulated debris, leaving the bowel fresh for the duties of the day.

To accomplish this a saline should be taken the first thing in the morning, a heaping teaspoonful, more or less as needed, of a good preparation, dissolved in a half-glass of cool water, and drunk during effervescence. Taken in this way (the more carbonic acid gas the better) one half hour before breakfast (time very important), it should act within two hours after breakfast, getting entirely out of the stomach before it receives food, thus flushing the entire canal for the digestive work of the day.

The best of all salines for this purpose is granular effervescent magnesium sulphate, c. p. Just enough should be taken to produce the desired effect one good, free, satisfying, gratifying, evacuation of a semi-solid consistency. Taking enough, and just enough, and taking it regularly under the conditions as outlined, no habit is established and the dose will not have to be increased. If irritating preparations are used, or if it is taken in any other way than suggested, this will not be the case. It is astonishing how much can be accomplished in the maintenance of health by the regular use of this preparation as outlined. Here is a pointer not only for many, many patients, but for the doctor himself as well. Should there be need for anything but the flushing, there may well be added to the toilet, other things in the way of digestives, general stimulants, etc., as have been so many times outlined.—*Exchange*.

#### BACTERIOLOGY AND PATHOLOGY.

G. MC F. MOOD, M. D.

##### ACTION OF VARIOUS SUBSTANCES ON PURE CULTURES OF AMOEBA COLI.

J. B. Thomas (*Amer. Jour. Med. Sciences*, January, '06) reports the action of various substances on pure cultures of the amoeba dysenteriae. Two series of tests were employed, using

amoeba No. 11,524, standard amoeba, Musgrave and Clegg, grown in pure strains in symbiosis with a single variety of bacteria, the cholera spirillum. The first series of experiments was made by pouring the solutions to be tested over the surfaces of 48 hour slant cultures of the amoeba, on the special agar medium, recommended by Musgrave and Clegg, and at the end of ten, twenty, thirty or sixty minutes, pouring off the solution, washing the surface, and making transplants to fresh media.

The second series of tests was made with the organisms grown as above, but suspended in a fluid. Controls were used in each instance. Results were as follows:

Thymol, 1:2500, destroyed the amoebae in 15 minutes, the cholera spirilla being effected only moderately.

Succinic peroxide acid, 1:1000; permanganate of potash, 1:2000; sulphate of quinine, 1:500; nitrate of silver, 1:2000; argyrol, 1:500; and protargol, 1:500, deterred the growth of the cultures within 30 minutes. This action, in the case of the silver salts and the succinic peroxide acid was due to destruction or inhibition of the growth of the symbiotic cholera spirillum.

Tannic acid, 1:100; and sulphate of copper, 1:2000, only moderately deterred the growth of the amoeba and spirilla.

Other substances used: boric acid, eucalyptol, ichthyol, oil of cassia, and infusion of quassia, had slight, if any, effect upon the amoeba.

#### INOCULABILITY OF CANCER.

Bashford, Murray and Cramer (*Berliner Klinische Wochenschrift*, Nov. 13, '05, *N. Y. Med. Jour. and Phila. Med. Jour.*, Dec. 23, '05) report having made 10,000 inoculation experiments, and have shown that only the cancer of the mouse is inoculable. The authors conclude that their experiments show that the malignity of a tumor is not directly dependent upon intracellular properties.

#### THE CAUSE OF TICK FEVER.

Dutton and Todd (*British Med. Jour.*, Nov. 11, '05, *N. Y. and Phila. Med. Jour.*, Dec. 2, '05) state that the cause of tick fever is a spirillum, probably identical with the spirochaeta obermeieri, and is transmitted by the horse tick, the ornithodoros moutaba.

The fever declares itself suddenly with a frontal headache, boneache, backache, loss of appetite and vomiting. There are usually three or four febrile attacks, lasting three or four days, with an interval of from five to nineteen days between each. Temperature rises to 104° F., or 105° F., and attacks end in a profuse perspiration. The most pronounced feature of the ailment is the prostration, and the terrible feeling of depression, during the febrile attacks. Equally marked is the sudden return to good health when the temperature falls.



## OBSTETRICS AND PEDIATRICS.

LANE MULLALLY, M. D.

## PREGNANCY ASSOCIATED WITH DIABETES.

Magnus Tate (*Am. Jour. Obstet. & Dis. of Women and Children*) after quoting the opinions of various investigators on this subject says that it is essential in grouping our cases to draw a distinct line between sugar in the urine due to lactose and diabetic urine.

When large quantities of urine are being passed heavily loaded with sugar and other symptoms of diabetes are present we have a grave condition before us. Tate says the theory now accepted is that the mammary glands being in a state of great activity on the third or fourth day of the puerperium, milk rapidly forms, the breasts become distended, milk sugar is absorbed into the blood owing to excessive production or diminished outflow of milk, and this milk sugar is excreted in the urine. That the symptoms which generally attract our attention to diabetes are, thirst, polyuria, and pruritus vulvae.

After citing a number of cases collected from literature with a short history of each, under *Results*, Tate says a woman who is diabetic rarely becomes pregnant, but if she does she is generally so debilitated that she will not carry the child to full term.

That diabetes in women of the child-bearing age results in suppression of menstruation, and even atrophy of the uterus. Tate gives the following as the results of Mathews Duncan's tabulated cases:

1. That Diabetes may come on during pregnancy.
2. Diabetes may occur only during pregnancy, being absent at other times.
3. Diabetes may come on soon after parturition.
4. Diabetes may cease with the termination of pregnancy.
5. Diabetes may not return in a pregnancy, occurring after its cure.
6. Pregnancy may occur during diabetes.
7. Pregnancy and parturition may be unaffected in its healthy progress by diabetes.
8. Pregnancy is very liable to be interrupted in its course and probably always by death of the foetus.

## TREATMENT OF TRANSVERSE PRESENTATION WITH REPORT OF A CASE.

Dr. John R. Hicks (*International Jour. Surg.*, Dec., '05.) believes the most logical treatment of transverse presentation is to put the patient in exaggerated Trendelenburg position and do external version. This he has found successful in two cases after labor had commenced. Having grasped the head and buttocks of the child he shoves the head of the child towards the mother's pelvis, and at the same time pushes the buttocks of the child towards the mother's head.

He then places two thick pads laterally far out to the sides of the mother's abdomen, and firmly presses them into the two iliac fossae, maintain-

ing the pads in position by means of a tight bandage, in order to prevent the child from returning to the transverse position.

## PRESENT DAY METHODS OF CONDUCTING LABOR CASES AND THE RESULTS OBTAINED.

Dr. John A. McKenna (*Jour. A. M. A.*, Dec. 16, '05) under the above title, writes an article in which he states "that within a period covering some seven years of private practice he had 207 confinement cases not only without a fatal issue to either mother or child, but without as yet a single development of any of the forms of grave puerperal troubles which eventually beset every obstetrician, such as sepsis, hemorrhage, eclampsia, severe laceration, etc."

This is, indeed, a wonderful record. We cannot help but feel that Dr. McKenna has been far more fortunate than any professional brother we know of who has practiced obstetrics.

He states that he made digital examinations, and given uterine douches to his puerperal patients whose temperatures have gone to 101 F. and over, he would certainly have had infected cases about which to compile statistics. His rule in labor cases is: Let nature do as much as possible in these cases, and only do that for the patient that nature seems unable to do. His conduct of labor consists in scrupulous cleanliness about the lying in room, as regards dressing, instruments, utensils, bed linen, etc. To make no vaginal examination unless the parts have first been cleansed with soap and water.

To swab out vagina with a gauze sponge. Thoroughly coat the finger nails and hand with soap after washing them in ether. Deliver in dorsal position. Support head and perineum by modification of Merkertschiantz's method, which reduces lacerations to a minimum, and what he deems most important, have the fundus of the uterus grasped before the presenting part is born, and held until the child is delivered, and cord tied. McKenna condemns the vaginal and uterine douche, believing more infective matter may be put in the vagina by the douche than flushing will bring away. He has never had a tear in which more than two stitches were applied. One case he reports in which a portion of the placenta was retained for fifteen days when it was discharged with a foul odor. The offensive odor began on the fourth day, but as the temperature never went above 100.3 F., and pulse 94, he did not interfere. Forceps were only used twice. He keeps patient's hips well raised in bed during the whole course of labor, to prevent any return flow of liquids into vagina, contaminated by contact with pad or bed.

Dr. McKenna's rules are simple, and apparently easily carried out. his results *marvelous*.

## ABDOMINAL OPERATIONS DURING PREGNANCY, WITH REPORT OF FIVE CASES.

Dr. H. A. Royster, of Raleigh, N. C., reports five interesting cases in a recent article under the above title.

Royster claims that surgical interference during gestation is a question of necessity, and not of complacency. That in the pregnant condition operation should only be resorted to in order to save life or to end suffering that cannot be otherwise relieved.

Royster claims that the death rate is no higher than in the non-pregnant, and the number of abortions small. That the greatest danger is withholding operation. That miscarriage is much more liable to occur as a result of a surgical operation during the first few weeks of pregnancy, and, therefore, if possible the operation be postponed until this period is passed. Royster directs attention to some of the conditions calling for opening of the abdominal cavity during pregnancy, viz.: fibroids and cancer of the uterus, ovarian cysts, lesions of the bowel, as appendicitis or intestinal obstruction, of the abdominal organs as gall-stones, rarer growths of liver pancreas and spleen. In regard to fibroids of uterus Royster quotes Frank (*British Gynecol Jour.*, Nov., 1903,) who sums up the indications for operating during pregnancy as follows:

1. If tumor is growing rapidly.
2. If circulation and breathing are disturbed.
3. If there is reason to suppose that the myomata may lead to a premature interruption of pregnancy.

4. If symptoms of peritonitis or incarceration appear due to the tumor. Keiffer's suggestion is also added. "That interference is demanded when independently of pregnancy the fibroid tumor would make hysterectomy justifiable." Royster cites two cases, and describes each.

CASE 1. Fibroma of the Uterus complicating Pregnancy. Total Hysterectomy at the third month. Recovery.

CASE 2. Uterine Fibroid complicating Pregnancy; Supravaginal amputation at sixth month. Recovery.

Under Ovarian Cysts one case is reported, viz., Ovarian Cyst with Torsion of the Pedicle (involving the Appendix) complicating a six months Pregnancy, Ovariotomy. Appendectomy. Recovery.

Royster claims there is no causal relation between appendicitis and pregnancy, and should appendicitis occur during pregnancy it is a stronger indication for intervention.

Royster reports a case of Appendicitis in the fifth month of Pregnancy. Removal of the Appendix. Recovery.

He concludes a most excellent article by a report of a case of "Intra-Uterine Pregnancy mistaken for Ectopic Gestation. Cyst removed and Uterus manipulated. Recovery with no interruption of the Pregnancy."

## LARYNGOLOGY AND RHINOLOGY.

W. PEYRE PORCHER, M. D.

### FACIAL NEURALGIA CURED BY COCAINE INJECTIONS INTO THE NERVE TRUNKS.

Walter Spitzmüller (*Wiener klinische Wochenschrift*, No. 40) reports a very severe case of trigeminal neuralgia, of several years' standing, upon which all the ordinary remedies had been used in vain, and a surgical operation was contemplated as a last resort. The patient was a woman, 32 years of age, who suffered almost constantly, and had repeated attacks of paroxysmal pain, lasting a week or longer. The following formula was used hypodermically:

R Cocaine hydrochlorati.....0.30 gramme;  
Suprarenin.....gtt vii;  
Aque destillatæ.....20 c.c.  
M. Ft. Sol.

Of this a half Pravaz syringe-ful was injected into the place of emergence of the left supra-orbital nerve, and the same solution was then injected into the infraorbital, the mental, and also the occipital. Immediate relief was afforded, the pain was as if "blown away." There was only left a temporary feeling of numbness in the distribution of the nerve. The patient now was able to take food, and had a good night's sleep, the first in two weeks. The next morning she had a little pain, and another half syringe-ful was injected as before, but in the right supra and infraorbitalis. During the next three weeks, nine injections were given, after which the patient remained free from pain. Six months later there had been no return of the neuralgia. The case is most instructive and the expedient deserving of extended use. The injections are free from danger; but they have the single objection of causing local tumefaction and ecchymosis, which, however, passes off in a few days. The reporter calls especial attention to the importance of making the injections directly into the nerve trunks, or at least in their immediate vicinity, so as to bring the solution in contact with the nerves.—*Exchange*.

### SALICYLIC IONIZATION IN AN OBSTINATE CASE OF TIC DOULOUREUX.

Professor S. Leduc, of Nantes (*La Semaine médicale*, November 22nd), reported last year several cases in which he had obtained excellent results in neuralgia by electrolytic introduction of salicylic ions (galvanic cataphoresis). Recently he has again resorted to this method with success in a case of tic douloureux of thirty-five years' standing. It affected all of the right side of the face, and the pain was constant. Frequent crises occurred, which were so severe that the patient lost flesh and his face constantly bore the appearance of acute suffering. He was cured, according to Dr. Leduc, in three séances by salicylic ionization. The method followed was to apply the cathode, moistened with a solution of salicylate of sodium, to the right side of the face, and at the first treatment the current was raised gradually to an intensity of 45 milliampères and maintained for forty minutes. After the second séance, which took place three days later (when the current was allowed to pass for one hour, with a current of 35 milliampères), he experienced decided amelioration. The pain now only returned during exposure to cold. Finally, a third and last ionization of forty minutes brought about a final cessation of the pain. From that time the patient's condition has been remarkably improved, and he has also even regained considerable flesh.—*Exchange*.

### TONSILLITIS.

Niles states that if every case of so called sore throat received the care and attention that an affection of so delicate and important a structure would seem to merit, much discomfort and suffering would be avoided, while unfortunate and



dangerous complications and sequelae would become much more rare. Tonsillitis naturally divides itself into the catarrhal, lacunar, and parenchymatous forms, each may be acute or chronic, single or combined. Quinine in tonic doses (2 grains three times daily) should be given, strychnine may be added, aconite controls the fever and may abort the disease. Sodium salicylate is advisable in cases presenting the rheumatic diathesis. Guaiac is also applicable as a gargle and a constitutional remedy. Anodynes may be required for pain, hypnotics for restlessness. The diet should be light, digestible and fluid, or semi-fluid. Nitrate of silver in solution painted over the tonsils is used. Iodine, bichloride of mercury, turpentine, phenol, sulphur are prescribed. Atomizers are useful.—*Exchange*.

#### NASAL INSUFFICIENCY.

Vacher classifies the causes of nasal insufficiency as nasal, pharyngeal, and buccopharyngeal. Among the nasal causes he includes all obstructions which occur in the entire nasal fossa from its anterior to its posterior aperture, and including both of these outlets. His pharyngeal cause is adenoids, while his buccopharyngeal is enlarged tonsils. He considers that nasal insufficiency predisposes to tuberculosis, and goes hand in hand with deafness.—*Exchange*.

#### MISCELLANY.

#### U. S. PHARMACOPOEIAL BUSINESS AFFAIRS.

The Board of Trustees met at Pittsburgh, December 2. Members J. H. Beal, A. E. Ebert, J. P. Remington, S. A. D. Sheppard and H. M. Whelpley were present. Horatio C. Wood was absent. Secretary Murray Galt Hotter has issued to the members the official minutes of the proceedings. A *resumé* of the work of Committee of Revision to be published in convenient form was discussed but no definite action was taken by the trustees.

An edition of the Pharmacopoeia in the Spanish language will, no doubt, be one result of the recent meeting. A committee consisting of Professor J. P. Remington, Chairman of the Committee of Revision, Charles E. Dohme, Chairman Board of Trustees, and Dr. H. O. Wood, President U. S. P. Convention, was appointed to make the preliminary arrangements for an edition of 2,000 copies. The discussion developed the fact that great interest is being taken in the proposition.

Dr. Walter Wyman, Surgeon General

of the Marine Hospital and Public Health Service, was tendered a special vote of thanks for the publication of Bulletin No. 23 entitled, "Changes in the Pharmacopoeia of the U. S. of A. Eighth Revision." Also, for the bulletin on Standardization of Diphtheria Antitoxins. A vote of thanks was also tendered Dr. Reid Hunt and Dr. Murray Galt Hotter, of the Service, for their work on Bulletin No. 23.

With a view of bringing the Pharmacopoeia to the direct attention of medical students, it was decided to present the professors of materia medica in the medical colleges with complimentary copies of the Pharmacopoeia. The recipients of such copies will be requested to call the students' special attention to the purpose of the Pharmacopoeia and the nature of official remedies.

The extent of additional honoraria to members of the committee of revision was considered at length, but action postponed until the next meeting of the board.

Several applications from publishers who desire to use portions of the text of the U. S. P. were discussed and the rate of compensation decided upon.

The board adjourned to meet at the Willard Hotel, Washington, D. C., January 20, 1906.

The Pittsburg College of Pharmacy tendered the Board of Trustees an informal dinner.

HENRY M. WHELPLEY, Sec.  
U. S. Pharmacopoeial Convention.

#### MILK MIXTURES.

The upper third of a bottle of milk (10 per cent. milk) or the upper half (7 per cent. milk) may be easily taken off with a spoon or with a special dipper. This dipper holds just one ounce and is convenient for dipping and measuring. With it the upper milk may be removed without disturbing the lower milk. It is known as the "Chapin dipper" and may be had at the druggist's at a small cost. In using a spoon it will be remembered that eight teaspoons are equivalent to one ounce, or four dessertspoons or two tablespoons.

During the first four weeks the infant is to be fed, as before stated, every 2 hours and takes about 2 ounces at each feeding. The food should be mixed in the morning for the entire day. It should then be placed in the nursing bottles, enough for a feeding in each bottle, or should be put in a covered glass jar and placed on ice. For the first weeks in life the baby will use 20 ounces a day. The following milk mixtures are based on that amount. It is easy to estimate the quantities for larger amounts. For a 25-ounce mixture, add one-fourth more of each ingredient. for a 30-ounce mixture add one-half more of each ingredient.

MILK MIXTURES.—(From Birth to Three or Four Months of age.)

1. Milk sugar, 1 oz. (3 level table-spoonsful.)

Lime water, 1 oz.

Enough hot water to make 20 ounces. After the milk sugar is dissolved add two ounces of upper third milk (10% fat.)

This is a suitable modified milk for the infant immediately after birth.

2 Milk sugar, lime water and water same as for No. 1, with the addition of 3 ounces of upper third milk.

3. Milk sugar, lime water and water as in No. 1, with the addition of 4 ounces of third milk.

4. Milk sugar, lime water and water as in No. 1, with the addition of 5 ounces of upper third milk.

5. Milk sugar, lime water and water as in No. 1, with the addition of 6 ounces of upper third milk.

6. Milk sugar, lime water and water as in No. 1, with the addition of 7 ounces of upper third milk.

Ten per cent. milk may be secured as shown in cut 1a from the upper third of the bottle of good 4% milk, or may be secured by mixing 2 parts of whole good milk with 1 part of cream.

If the baby is artificially fed from birth, begin with Mixture No. 1. Substitute the succeeding mixtures gradually until the third or fourth month. After the

fourth month the above mixtures are not strong enough.

In weaning an older infant, use the mixture suited to the age of the child from the above or from following mixtures.

MILK MIXTURES.—(From the Third or Fourth Months to the End of the Ninth or Tenth Month.)

For these formulas is used the upper half milk as shown in Cut 1b, or milk containing 7% fat. This may be secured not only from the upper half of the bottle of good milk, but also by mixing 3 parts of good milk with 1 part of cream.

1. Milk sugar, 1 oz. (3 level table-spoonsful.)

Lime water, 1 oz.

Enough hot water to make 20 ounces. After the milk sugar is dissolved add 3 ounces of upper half milk.

2. Milk sugar, lime water and water as in No. 1, with the addition of 4 ounces of upper half milk.

3. Milk sugar, lime water and water as in No. 1, with the addition of 5 ounces of upper half milk.

4. Milk sugar, lime water and water as in No. 1, with the addition of 6 ounces of upper half milk.

5. Milk sugar, lime water and water as in No. 1, with the addition of 7 ounces of upper half milk.

6. Milk sugar, lime water and water as in No. 1, with the addition of 8 ounces of upper half milk.

7. Milk sugar, lime water and water as in No. 1, with the addition of 9 ounces of upper half milk.

8. Milk sugar, lime water and water as in No. 1, with the addition of 10 ounces of upper half milk.

9. Milk sugar,  $\frac{3}{4}$  oz.

Lime water, 1 oz.

Enough water to make 20 ounces.

To this add 12 ounces of upper half milk.

Of the above formulas, it is seldom necessary for the healthy infant to use a mixture of less strength than No. 5. Nos. 1, 2, 3 and 4 are of value, however, during temporary disturbances of digestion



when it is desired to relieve the digestive organs of as much work as possible.

The infant which can take Mixture No. 9 of the above formulas without difficulty is usually able to begin on No. 5, of the following formulas, in which whole milk (4%) is used.

**MILK MIXTURES.**—(For the latter part of the First Year.)

1. Milk sugar, 1 oz.  
Lime water, 1 oz.  
Enough hot water to make 20 ounces. After the milk sugar is dissolved add 5 ounces of whole milk.
2. Milk sugar, lime water and water as in No. 1, with the addition of 6 ounces of whole milk.
3. Milk sugar, lime water and water as in No. 1, with the addition of 8 ounces of whole milk.
4. Milk sugar, lime water and water as in No. 1, with the addition of 10 ounces of whole milk.
5. Milk sugar,  $\frac{1}{2}$  oz.  
Lime water, 1 oz.  
Enough water to make 20 ounces. to this add 12 ounces of whole milk.
6. Milk sugar, lime water and water as in No. 6, with the addition of 14 ounces of whole milk.
7. Milk sugar, lime water and water as in No. 5, with the addition of 16 ounces of whole milk.

For mothers who do not get milk in bottles and who have difficulty in using the above formulas, the following excellent mixtures are given. They are simply made and prove satisfactory for most infants.

For a new-born baby, or one a month or two old, take 1 ounce of fresh milk; 3 ounces of water; 1 ounce of fresh cream, and 2 level teaspoonfuls of milk sugar. This makes about 5 ounces. For 20 ounces use four times as much of each ingredient. This closely resembles mother's milk.

For older babies, take 2 ounces of fresh milk; 2 ounces of water; 1 ounce of fresh cream; 2 level teaspoonfuls of milk sugar and a teaspoonful of lime water. Larger

quantities may be made by increasing the amounts of each ingredients in proper proportion. More milk and less water will be used as the infant increases in age.

If cream disagrees with the infant its use should be stopped temporarily. The following is a good substitute for mother's milk suitable for an infant of three months or less: Pure milk, 1 cupful; water, 2 cupsful; sugar of milk, 1 heaping tablespoonful, and lime water, 1 tablespoonful.

Milk sugar should always be dissolved in hot water. It sours quickly when dissolved, so not more than one day's supply should be prepared at a time.—*Circular issued by the Illinois State Board of Health.*

#### AFFILIATED COUNTY SOCIETIES WITH MEMBERS.

(The Secretary begs to announce that this list will appear for several issues, in order to make the same as complete as possible.

He requests that he be notified promptly of any errors or omissions.)

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C. Henslee.....Dillon.  
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W. G. White.....	Yorkville.

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1871.....	T. G. Simons.....	Charleston.
1872.....	J. C. Spann.....	Catchall.
1873.....	A. A. Moore.....	Camden.
1873.....	M. G. Salley.....	Pinewood.
1873.....	R. L. Brodie.....	Charleston.
1874.....	W. H. Nardin.....	Anderson.
1874.....	J. F. Pearce.....	Claussens.
1874.....	O. B. Mayer.....	Newberry.
1875.....	T. G. Croft.....	Aiken.
1875.....	Manning Simons.....	Charleston.

The following Counties have not yet affiliated:

Bamberg.	Edgefield.
Beaufort.	Georgetown.
Berkeley.	Lancaster.
Chesterfield.	Orangeburg.
Clarendon.	Williamsburg.
Darlington.	

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### South Carolina Medical Association.

Next Annual Meeting at Columbia, S. C.,  
April 18th, 1906.

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# THE JOURNAL

OF THE

## SOUTH CAROLINA MEDICAL ASSOCIATION.

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4 Vanderhorst Street, Charleston. S. C.

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ROBERT WILSON, Jr.,  
Editor.

T. P. WHALEY,  
Associate Editor.

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ANNUAL SUBSCRIPTION, \$2.00.

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THE JOURNAL is published monthly under the auspices of the South Carolina Medical Association. Members who do not receive their copies will please notify the Managing Editor at once. Secretaries of county societies are requested to send reports of their meetings, and items of news that may be of interest to the profession. Original articles are solicited. Articles should be type-written; and illustrations sent with articles will be printed at the expense of the writer. Reprints will be furnished at the rate of 75c. a page for a hundred copies.

All matter must be in the hands of the editor by the 10th of each month.

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### EDITORIAL COMMENT.

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#### THE FAILURE OF THE BILL TO REGULATE THE SALE OF NOSTRUMS.

---

During the present session of the General Assembly a bill was introduced whose object was the restriction of the sale of proprietary compounds and nostrums by requiring the manufacturers to print the formulae plainly upon the labels. The bill failed. It seems that a delegation of druggists visited the Capital and convinced the legislators that should the bill become a law the result would be simply a diversion of the revenue of the traffic into the pockets of dealers in other states, and not a restriction of the sales with protection to the public as was contemplated, and that such a diversion would be not only unjust, but very injurious, to our own drug sellers. The bill, in other words, irritated the sensitive pineal gland of the pharmaceutical body and

aroused a lively response. But while the well organized Pharmaceutical Association protested strongly and effectively the Medical Association made no properly directed effort in behalf of a measure admittedly desirable. We have been reliably informed, indeed, that the opposition was supported to some extent by physicians. We are able to comprehend, even if we do not sympathize with, the action of the druggists, but we neither understand nor excuse the indifference of physicians to a measure which concerns one of the most important planks in our platform. Are we going to do better in the future? The recent occurrence points clearly the way we must go and the methods we must pursue if we are to attain our ends and overcome the nostrum evil. Desirable as we believe such a law as that proposed may be, the truth must be admitted that legislative enactment will not create morals and high ideals, and our first step, therefore, should be an endeavor to bring our friends the druggists into sympathy with ourselves. We believe that their best interests will be served by working in association with physicians and not in opposition. Pharmacists and physicians should be closest friends as they are mutually dependent, and their aims and ideals should be in harmony. However commercial their recent action may indicate them to be, we believe that if we could get together the result would be a better understanding and a higher conception of the duty which they, as well as we, owe the public. To this end a committee was proposed at the last annual meeting of our State Association, and provided for by the House of Delegates, but it has never been appointed.

Further, we must pursue a consistent campaign of education, for in ignorance lies the root of the evil. We must prepare ourselves by following the example of the good parson of the Canterbury Pilgrimage who first "wroughte and after that he taughte." Individually and collectively we must try systematically to teach the public the dangers that lie behind trade-mark names and secret formulae,—teach them that "if such nostrums are of



real efficacy, any concealment regarding them is inconsistent with beneficence and professional liberality, and if mystery alone give them public notoriety, such craft implies either disgraceful ignorance or shameful avarice." Let us take up this matter at our annual gathering in April and see if we cannot formulate a definite plan of action.

#### AN EXAMPLE FOR SOUTH CAROLINA EDITORS.

That the spirit of commercialism does not exercise its baneful influence upon all newspapers is manifest from the following note from the *Journal of the American Medical Association*:

The *Ashland* (Neb.) *Journal* declares that it will not take advertisements from fraudulent patent medicine companies. It expresses its indignation over the fact that newspapers which should stand as defenders of the home accept the advertisements of these frauds and help them reach their victims. The editor admits that some testimonials are genuine and that some persons are helped by these nostrums, but he calls attention to the fact that the same can be said about whisky, and that both the nostrums and the whisky are responsible for thousands of dishonored graves, wrecked lives, ruined homes and broken hearts. The editor says further that his paper "needs advertising as badly as any paper in the State, but it does not need it badly enough to accept one line that it does not believe is thoroughly reliable, and we have no space for any medicine we do not know to be absolutely reliable."

"Ashland has a number of physicians whose abilities and characters stand unquestioned. We have drug stores where absolute honesty and accuracy are beyond doubt. Our physicians and druggists are men whom one can trust with the health and welfare of his loved ones with perfect confidence that the trust will be regarded as sacred and holy—men who would not endanger the lives of their patients for any amount.

"Health is the most precious blessing of this life, and we can not guard it too carefully. Don't risk it with patent medicines put up by strangers. Go to your home doctor."

Is it too much to hope that South Carolina editors may in like manner throw off the shackles and stand out bravely for honesty and truth and purity—not in editorial theory but in fact?

#### UNION COUNTY MEDICAL SOCIETY.

Union County has a live and active medical society whose earnestness and zeal are worthy of commendation and

may be imitated profitably by the rest of us. They are endeavoring to cultivate pleasant relations with one another by gathering together at frequent intervals, and are reaching after higher professional attainment by the prosecution of scientific work at every meeting. That the influence of their earnest work is making itself felt upon their community is shown by the request of the trustees of the Graded Schools that the society supply a lecturer to instruct the higher classes in practical hygiene. Such action is evidence both of an enlightened board of school trustees who are able to appreciate the fundamental importance of a knowledge of the laws of health, and of the growing strength and influence of the medical men. Here is a society which is performing its true functions and justifying its existence. We wish them a long life of continued and broadening usefulness.

#### BILL TO REQUIRE THE USE OF METRIC SYSTEM IN GOVERNMENT DEPARTMENTS.

Those interested in the progress which the Metric System is making in this country, will be gratified to learn that on December 18th, 1905, Mr. Littauer introduced the following Bill in the House of Representatives which was referred to the Committee on coinage, weights and measures and ordered to be printed:

##### A BILL

To fix the standard of weights and measures by the adoption of the metric system of weights and measures.

1. BE IT ENACTED BY THE SENATE AND HOUSE OF
2. REPRESENTATIVES OF THE UNITED STATES OF AMERICA IN CONGRESS ASSEMBLED,
3. That from and after the first of July, nineteen hundred and eight, all of the Departments
5. of the Government of the United States, in the
6. transaction of business requiring the use of
7. weight and measurement, shall employ and use
8. the weights and measures of the metric system.

The passage of the above bill will be a great step to further the practical adoption of this measure. An absolute scientific matter of this kind should be uninfluenced by any political party, and it

is hoped that it will meet the universal approbation of all our representatives. The metric system has for many years been considered the language of science in regard to metrology, and measures of this kind will not only greatly enhance its value from a scientific standpoint, but will greatly increase its practical applicability.

---

### ORIGINAL ARTICLES.

---

#### SOME REMARKS UPON GALL-STONES\*

---

LINDSAY PETERS, M. D., COLUMBIA, S. C.

(Formerly Asst. Res. Gynecologist to Johns Hopkins Hospital and Assistant at Dr. H. A. Kelly's Sanatorium.)

---

Mr. President and Gentlemen:—When I received the invitation to prepare a paper for your society, it was accompanied by the suggestion that I choose a subject of interest to the general practitioner. In casting about for a subject, one which appeared to me to fulfill this condition was suggested by the recollection of three cases observed during the past two and a half years, which have made such an impression upon me that I trust they will also prove of interest to you. One was a patient of Dr. Weston, who suffered from gall-stone colic, who refused operation and about a year later was stricken down with excruciating agony ending in death, the autopsy showing a small gall-stone in the diverticulum of Vater and typical acute hemorrhagic pancreatitis, which had been diagnosed before death.

The second case was that of a man, who, following only moderate discomfort in the gall-bladder region, developed profound jaundice and persistently declined operation until in a desperate condition from cholemia and septicæmia. He was practically an invalid for 8 months before coming into my hands, has had to undergo three serious operations upon the gall-bladder and common duct and will probably never be entirely well.

---

\*Read before the Kershaw County Med. Soc., at Camden, S. C., Jan. 24, 1906.

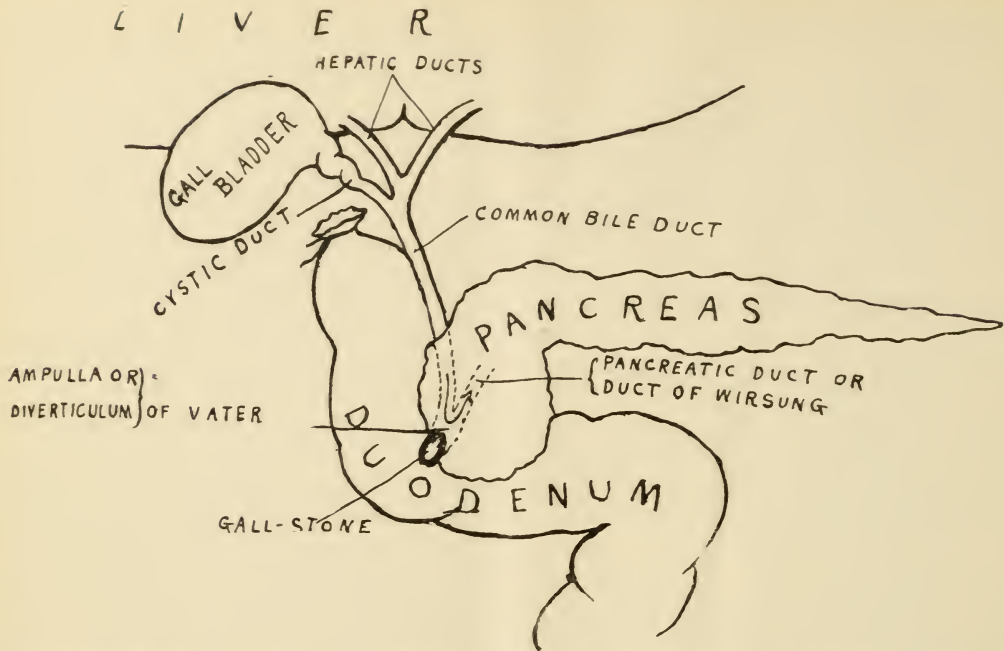
The third case was that of an eminent professor at South Carolina College whom I saw in his office the next morning after a moderately severe, but transient, attack of abdominal pain, which he attributed to "indigestion." About a year later he was seized with the illness which caused his death and which proved to be acute hemorrhagic pancreatitis, superinduced by the presence of a gall-stone in the diverticulum of Vater.

These cases illustrate the lamentable results which may be the outcome of neglected gall-stone disease. That these results, or others equally disastrous, are far from uncommon is being more and more clearly recognized and is shown by the large number of personal cases in the literature reported by individual observers. In view of this fact, the importance of the subject of gall-stones to the general practitioner, as well as to the surgeon, is unquestionable, and it is this subject which I have chosen for my remarks to-night.

Gall-stones are, in the great majority of cases, formed in the gall-bladder, but rarely they are formed in the bile-ducts in the substance of the liver, sometimes in great numbers, as is impressively illustrated by a case recently reported by Dr. McArthur, of Chicago, in which the following condition was found at operation: The gall-bladder was moderately distended, but contained no stone. Palpation of the common duct revealed a hard, cylindrical tube  $1\frac{3}{4}$  inch in diameter; on opening the common duct by an inch incision, there escaped innumerable gall-stones (246 were counted) the size of a pea, floating, not in bile, but in pus of the same stinking character as characterizes an appendical abscess. As fast as the stones could be ladled out with a large gall-stone spoon, more would appear until, considering the desperate condition of the patient, it was deemed advisable to remove only those obstructing the duodenal end of the common duct. Two fingers could be passed along the duct.

At autopsy many small stones were found still in the common duct. There was suppurative cholangitis, extending into the lesser hepatic ducts and wherever an incision was made into the liver,





*Diagram showing mechanism of production of pancreatitis by gall-stones, as demonstrated by Opie.*

The stone plugs the orifice of the papilla, but is not large enough to fill the ampulla or diverticulum of Vater, thus leaving a space through which bile is retrojected into the pancreatic duct, thereby exciting inflammation of the pancreas.

calculi of varying size were seen in the bile ducts.

W. Monroe Smith has also reported a case of nodular liver tumor in which 71 gall-stones, some of large size, were impacted in the liver substance. These were successfully removed by operation. Such cases as these are rare, but it is well to bear them in mind, as a possibility in explaining the apparent reformation of stones after operation for gall-stones.

The number of gall-stones found in the gall-bladder may vary from a single stone to a very large number. Occurring singly, they are apt to be large; when in greatest numbers they may be as small as grains of sand—i. e., their number is in inverse proportion to their size. A gall-stone may occasionally attain an immense size, such as the one reported by Russell, which measured  $5\frac{3}{4} \times 4\frac{1}{2}$  in., and weighed 530 grains. The patient from whom this stone was removed had never been known to complain of symptoms referable to the gall-bladder, which is simply an illustration of the well known fact that gall-stones may exist for an in-

definite time, or may even cause death, without giving rise to symptoms pointing to their presence.

Single gall-stones are, as a rule, fairly regularly oval or rounded, but when multiple they are usually fascetted where they impinge upon one another, this giving them a polygonal form. In color they vary from a clear, crystalline stone to one of dark brown, greenish or jet-black color, according to their composition. They consist of cholesterin, bilirubin calcium, or a mixture of these substances in varying proportions. Mixed stones are the rule, pure cholesterin or pure bilirubin calcium stones being rare. A pure cholesterin stone is clear and crystalline.

The interesting and instructive statistics of Mosher, compiled from the records of 1,655 complete autopsies in the Pathological Department of Johns Hopkins Hospital, confirm the usual statement that gall-stones are rare before the 30th year and more frequent after that period, their frequency increasing *pari passu* with the increase of age. According to these statistics gall-stones occur in 2.6% of

white men and women from 31 to 40 years of age, in 5.8% from 51 to 60 years, and in 15.8% above 60 years of age. In the 133 autopsies upon subjects under 21 years old, no gall-stones were found. The percentages were somewhat smaller for the negro than for the white race. Gall-stones were found in 9.3% of females, without respect to age, as compared with 5.5% of males. The greater frequency of gall-stones in women is ascribed to a number of predisposing conditions to which men are not subject, namely, (1) the wearing of clothing tight about the waist, which changes the type of breathing from diaphragmatic to costal, thereby producing stagnation of bile by the suppression of the action of the diaphragm; for Heidenhain has shown that the descent of the diaphragm is an important factor in emptying the gall-bladder. Tight clothing may also produce artificial deformities of the liver which cause mechanical obstruction to the outflow of the bile; (2) lax abdominal walls from repeated pregnancies, leading to enteroptosis and alterations of the normal relations of the gall-bladder which hinder the flow of bile; (3) large abdominal or pelvic tumors or the pregnant uterus and other causes producing constipation.

Knowledge of the causes and process of formation of gall-stones is a recent acquisition due to the pathologists, the bacteriologists, and the physiological chemists. The results of numerous experiments have shown that there are three conditions essential to the production of stones in the gall-bladder: 1st, the presence of attenuated bacteria in the bile; 2nd, the existence of catarrhal inflammation of the mucosa of the gall-bladder; 3rd, a retardation of the flow of bile. A virulent culture of bacteria injected into the gall-bladder will produce a severe inflammation, but never a gall-stone; the virulence of the bacteria must be attenuated in order to set up the catarrhal inflammation which is essential to the production of stones. The mere presence of bacteria in the bile, without inflammation of the mucosa of the bile tracts, will not produce calculi. Gall-stones cannot be

made to form in a gall-bladder in which the flow of bile is free and unobstructed.

Bacteria may gain entrance to the bile tracts through the general blood currents from the portal circulation or by direct extension from the intestines. When these attenuated organisms reach the gall-bladder, let us suppose the outflow of bile to be impeded and we have the conditions favoring the induction of a catarrhal inflammation, attended with the outpouring of mucus and the elaboration of cholesterolin by the diseased epithelial cells of the mucosa. The stagnant bile becomes thick and viscid in the dependent part of the gallsac, the bacteria become clumped together in little masses, with which the inspissated bile, mucus and cast off epithelial cells become entangled and thus form nuclei about which the altered biliary pigment, together with cholesterolin, forms successive concentric layers. It is thus that gall-stones are formed and grow. It is probable that some large gall-stones are the result of fusion of smaller ones. Bacteria have repeatedly been demonstrated in the centers of gall-stones, Welch having found the streptococcus, as well as bacillus typhosus and bacillus coli communis. It was formerly believed that bile possessed bactericidal properties, but this has been found to be true only of fresh bile, this secretion acting as a good culture medium for certain organism when stagnant.

From the above facts, it is clearly seen how certain diseases characterized by the presence of bacteria in the blood stream such as typhoid fever, puerperal infection, etc., predispose to gall-stones. The colon bacillus is the organism most commonly found in gall-bladder infections and in the nuclei of gall-stones. It is characteristic of this organism that, occurring alone, it is innocent and harmless, but when implanted upon another infection it is capable of acquiring great virulence. Welch is of the opinion that the colon bacilli found in the gall-bladder have usually been originally implanted upon a primary infection by another organism.

Gall-stones may, as has already been stated, remain quiescent in the gall-bladder for an indefinite period, but they are



prone to set up an inflammation of the gall-bladder, which, as a rule, produces pain or soreness. They are also becoming more and more generally known as a frequent factor in the causation of symptoms of "indigestion," "dyspepsia," "gastritis" and the like, even when giving rise to no actual pain.

A gall-stone may find its way from the gall-bladder into the cystic duct, thence into the common duct and through the orifice of the duct in its duodenal papilla, into the bowel. The passage of the stone is usually attended with the agonizing pain known as gall-stone colic but stones have often been found in the common duct without having caused severe suffering at any time. The stone may make its way out through the bowel without interruption, but it may also be arrested in any part of its passage through the ducts. If this occurs in the cystic duct, an inflammation of the gall-bladder, with distention, is the usual result; if it occurs in the common duct, jaundice is produced, which varies in intensity according to the completeness of closure of the lumen by the stone. Generally the closure is not complete and permanent, a little bile escaping past the irregularly shaped stone or the closure may be intermittent owing to the slipping back and forth of the stone in the duct. This is known as the ball-valve action of a calculus. Opie, *J. H. H. Bulletin*, Vol. XII, p. 182, 1901, has beautifully demonstrated the role of gall-stones in the production of disease of the pancreas, by causing a retrojection of bile into the duct of Wirsung. (See diagram.) To accomplish this a stone must be lodged in the ampulla or diverticulum of Vater of such size that it is too large to pass through the orifice of the papilla, but too small to completely fill the ampulla. In such a case, the pressure of the bile closes the orifice of the papilla by forcing the stone against it; there being no other escape for the bile and the unoccupied space of the papilla forming a communication between the termination of the bile duct and the pancreatic duct, the infected and irritating bile is forced from the former into the latter, setting up an inflammation of the pancreas.

That a stone may continue to grow after becoming lodged in the ducts is the logical inference from the frequent observation of stones in the common duct much too large to have passed through the bile tracts above them with their present dimensions.

Infections produced by the presence of gall-stones may vary in severity from a mild catarrh to gangrene and rupture of the gall-bladder. When suppurative inflammation occurs it is common for the infection to extend up into the smaller radicals of the bile ducts in the liver substance, giving rise to an accompanying cholangitis.

In dealing with inflammations of the gall-bladder we are prone to think of them as distinctly localized affections, but Eisendrath, in a most instructive article on cholangitis, reminds us that the inflammation may extend upward through the bile ducts into the liver substance itself. He says (speaking of cholecystitis): The inflammation may be catarrhal, purulent, or gangrenous. The catarrhal variety frequently subsides, but in the purulent bacteria may spread along the bile ducts into the liver, producing either a purulent or non-purulent cholangitis. The latter process is especially likely to occur when any cause for bile-stagnation, for example, stone in the common duct, exists. The clinical picture of cholecystitis usually predominates, so that the cholangitis, with its grave influences upon the liver parenchyma, is masked.

Symptoms of cholangitis complicating gall-stones are that, after one or more attacks of colic, there is a more or less marked tendency to fever, icteric hue and dull pain in the liver region. The fever may be of the type first described by Charcot and frequently miscalled hepatic intermittent fever. The more or less regular recurrences of chill, fever and sweat resemble malaria greatly. In this variety there may be multiple abscesses in the liver (purulent cholangitis). Later the clinical picture may be that of a septicopyemia, with endocarditis, etc. Pick noted during the attack a marked decrease in the excretion of urea and an increased leucocytosis.

In cholecystitis there is always pain over the gall-bladder, radiating to the shoulder—no icterus, as a rule, no enlargement of the liver. There is usually some fever, especially if there is pus present. It is not of the septic type, as in cholangitis. Generally a tumor can be felt, but where the process has existed for some time the gall-bladder may shrink so that none can be felt.

The non-purulent form of cholangitis complicating gall-stones is not characterized by as marked emaciation, rise of temperature or septic symptoms as the purulent form. Its course is more prolonged and there is not apt to be much jaundice.

Cholangitis is not so important of itself as that its sequelae, abscess-formation and parenchymatous changes in the liver, may be very serious.

Cases have been reported of gall-stones which have become lodged in the vermiform appendix in their passage through the alimentary canal.

Stones may produce a perforating ulceration of the gall-bladder and escape through the perforation into an adjacent coil of intestine or into the abdominal cavity. When this occurs the stones are usually large and when discharged into the bowel often produce intestinal obstruction; if they are discharged into the abdominal cavity and the patient survives the accident, they cause a burrowing abscess, which may discharge at some remote point, provided the patient lives long enough.

The frequent association of gall-stones with carcinoma of the gall-bladder throws strong suspicion upon the stones as being the exciting cause of the malignant growth.

The above review of the possible evil consequences of gall-stones could be elaborated, but is sufficient to emphasize the importance to the general practitioner of a knowledge of the pathology and symptoms to which these calculi give rise. It is not the purpose of this paper to set forth in detail these phases of our subject, and I will merely endeavor to present the clinical picture by which the condition most frequently manifests itself. I will repeat that gall-stones frequently fail to

cause any symptoms which would reveal their presence and it is very often impossible to make a positive diagnosis of their presence or absence, when they are under suspicion.

I have seen patients who gave a history of a "burning sensation" or "sense of heaviness" in the pit of the stomach after eating previous to an operation for another cause, in the course of which gall-stones were incidentally found and removed, with relief of the above-mentioned symptoms. The fact is, our knowledge of the early stages of gall-tract infections is very indefinite and many cases come to operation for the relief of very serious symptoms in which there is no history of colic or of jaundice, which symptoms we have been taught to look for as essential in all gall-stone cases; and if nothing else which I have to say to-night is remembered, I wish to impress upon you that not only is this idea erroneous, but on the contrary, the presence of a noticeable jaundice is the exception rather than the rule in gall-stone cases. The failure to convince ourselves of this fact will be the cause of our misinterpreting many of the early symptoms of gall-stones. The symptoms of typical gall-stone colic are sufficiently familiar to you and it is needless for me to describe them, but I will say again that gall-stone colic may be typical without jaundice. In all attacks of "indigestion," "gastritis" or "dyspepsia" it is well to bear in mind the possibility of gall-stones and to examine carefully for tenderness on pressure, or a palpable mass in the region of the gall-bladder. The presence of either tenderness or palpable swelling would tend to confirm the suspicion of stones in the gall-bladder, and jaundice in such a case would make the diagnosis conclusive, although the absence of the latter symptom would not exclude gall-stone. In some cases in which the size or number of the gall-stones was very large, and the abdominal walls very thin, it has been possible to actually feel the stones grating upon one another or even to hear them on listening with a stethoscope.

When the diagnosis of gall-stones has been unquestionably established by find-



ing the stones in the stools after an attack of colic, or by other means, the question arises as to the probability of all the stones having been passed. Apropos to this question, W. J. Mayo, one of the greatest authorities on gall-stones, states that *he has never operated upon a patient who has passed gall-stones without finding more in the gall-bladder.* While the hope of the patient that the stones will pass down and out through the common duct frequently materializes, usually more are left behind.

It is plain, in view of the foregoing facts, that a patient in whom gall-stones have formed, although the stones be dormant, is in constant danger from their presence.

As in appendicitis it is easy and safe to remove the disease in its earliest stage, so is it possible to remove gall-stones with little risk of death from the operation when the stones are quiescent and have done little damage to their containing organs or those adjacent to them. The statistics of Kehr, Mayo and Mayo Robson show less than 2% mortality for cholecystostomy performed for marked symptoms. The existence of gall-stones having been ascertained, therefore, the risk of death from operation for removal of the stones is less than the chance of a fatal result from the effects of the stones without operation. The chances are great that, even though they do not cause death, they will interfere with the enjoyment of perfect health to the extent of producing symptoms of acute or chronic gastric derangement or even chronic invalidism. In an abstract in the *Journal of the American Medical Association*, of an article by Norman Bridge, of Los Angeles, this point is discussed so clearly and so exactly in accordance with my own views that I will quote it in full:

He states that the physician can often present the urgency of an operation to the patient better than the surgeon. Most people dread operation and many suspect the surgeon of having undue enjoyment in the act of operating and of being biased by visions of large fees. The physician is, for these reasons, a more acceptable counselor, but even he, in these latter

days, is not free from the suspicion of seeking a part of the surgeon's reward.

The author cited cases to illustrate the long continuance of gall-bladder symptoms without recognition.

Whether operation should be done in all cases of proven gall-stones or of suppuration or distension of the gall-bladder, is the same question over again of the misfortunes of the appendix. Cases become quiescent, or recover and remain so for years, even with gall-stones, the patients dying of other disease or of old age. Hence one camp of physicians contends that in all such cases we should wait; not operate until forced to it by some urgent symptoms or situations. The other camp says that, for the sake of safety, operation should always be done promptly, since the next attack might prove fatal. Both are in part right; neither can prove the other wholly wrong.

People are taking great personal risks in manifold ways all their lives, and with the lightest thought, but if one suffering from cholelithiasis, to the extent of producing marked symptoms, would minimize to the lowest point his danger of death from it, he will probably have it dealt with surgically, always provided he has a surgeon who is wise in pathology and procedure, as well as expert in technique, and provided the patient has good vital organs. That statement is still true of the diseased appendix; it is true of gall-stones and gall-bladder infections as well.

All cases of chronic cholelithiasis, where the suffering has led to the opium habit, should be operated on. Every case of known distension of the gall-bladder by fluid of any sort is in constant peril, and should be operated, if possible. If there is reason to believe the gall-bladder contains pus, operation is urgently demanded. And in all cases where frequent recurrences or the persistence of symptoms indicate the progressive contraction and fibrosis of the gall-bladder, operation should be insisted on, for in these there is constant danger of an explosion of infection that may destroy life.

All cases of proven gall-stones or gall-bladder troubles are proper subjects for

surgical consultation, whether they are to be regarded as surgical cases or ever to come to operation. Whether operation is to be done or not when conditions do not sound the insistent needs of an operation, or the patient declines, or the physician sees reasons against an operation, proper medical treatment should be instituted always, and persistently carried out. This is as true of gall-stone troubles as it is of those of the appendix.

What are such measures? In the acute cases, there should be absolute rest of the body. Rest of the stomach and bowels to the extent of starvation for some days is best, especially where peritonitis is present or threatened. Nutrient enemias may be allowed tentatively, but never nutrition by the stomach in such cases. The upper abdominal organs must be kept still, not be shaken about by peristaltic movements.

In the subacute and chronic cases, the daily flushing of the bowels by alkaline laxative waters is useful, but it is irrational to suppose that gall-stones are thus washed away. Nor do olive oil or any other of the pretended expulsive agents have the smallest effect. The thing that happens is probably merely the limination of effete matter, thus increasing the physiologic resisting power. This process is aided by a restricted diet of the most assimilable foods, and by general good hygiene.

Ochsner, of Chicago, extols the efficiency of gastric lavage for the relief of gall-stone-colic, this treatment being based upon the idea that the pain is due to spasmodic contractions of the gall-bladder synchronous with contractions of the stomach and these are abolished by removal of all food from the stomach which might excite peristalsis.

Since I am confining my remarks to the points of especial interest to the general practitioner, I will not discuss the various surgical procedures proper for the different conditions found at operation, but will conclude with a reference to the results of operation in 1,000 cases published by W. J. Mayo, the favorable result of which I trust will persuade you that in the majority of cases the conservative treatment for gall-stones is surgical.

In the 1,000 operations there were 50 deaths (5%).

In 960 for benign disease the mortality was 4.2%.

In 673 cholecystostomies the mortality was 2.4%.

In 186 cholecystectomies the mortality was 4.3%.

In 137 common duct operations the mortality was 11%.

4% of the cases were malignant and operation upon these gave 22.5% mortality.

In no case did stones reform in the gall-bladder. The combined experience of all the great authorities on gall-stones shows that the possibility of reformation of the stones after operation for their removal is theoretical, rather than real.

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#### ACUTE BRONCHO-PNEUMONIA.\*

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J. FRANK WILLIAMS, M. D.,  
ROEBUCK, S. C.

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You will pardon me for thrusting upon you an old enemy, Acute Broncho-Pneumonia. Not that I can or may say anything new on this subject, but I wish only to lay stress on what I consider some important factors in the management and treatment of this much dreaded disease of children.

In my judgment there is no disease that should command more careful and painstaking attention. It is the children of to-day that are the men and women of the world to-morrow, so to speak, therefore, as physicians, let us keep ourselves well fortified to stay, if possible, the ravages of this dreaded disease.

In broncho-pneumonia, in its incipient stage, there is a superficial process of inflammation involving the larger bronchi.

In a short while this inflammatory process deepens and diffuses itself. The exudation drops into the air vessicles, thereby, in my judgment, forcing the lesion to be somewhat irregularly distri-

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\*Read before the Spartanburg Co. Medical Association Dec. 23, 1905.



buted. Mainly, however, in the small bronchi, and from this point it makes its rapid invasion.

It is not my purpose to enter into the different anatomical changes in this disease, but to dwell mainly on the etiology, symptoms, and treatment. As to the source of this disease, I think the mouth and nose furnish the main channels for infection; though I confess I am somewhat skeptical as to infection by bacteria.

Broncho-pneumonia is essentially a disease of infancy and childhood. The larger per cent. of cases are found occurring under two years of age. Indeed, more than sixty-five per cent. of the cases coming under my observation are below this age. As to sex, my cases have been about evenly divided, with possibly a few more males than females. As to season, ninety-five per cent. of my cases have occurred during the winter months, though I have seen a few cases occurring during the month of November just passed, when we had a long dry spell, and a lot of dust was diffused through the air, which, I think accounts for these cases.

Previous health and conditions are very important factors in the cause of this form of pneumonia. Children already weak and debilitated from any cause are much more liable, especially if bad hygienic surroundings exist. Broncho-pneumonia has no set course to pursue.

Prof. Holt divides the symptoms into three different types, viz.: the acute congestive type, the disseminated type, and the common type, which, in my judgment, is correct. The acute congestive type is the most dangerous, and in my opinion the most fatal of the three types. The symptoms are few. High temperature, very rapid respiration, patient prostrated almost from the beginning, and often not lasting more than twenty-four hours. These are the cases that may lead us to sometimes doubt our diagnosis. In this type cough is absent.

The second type, disseminated broncho-pneumonia, sometimes called capillary bronchitis, as its name suggests, often follows or is associated with bronchitis. The temperature is not so high, usually

ranging from 100 to 102 degrees, lasting from four to six days. Breathing is rapid, pulse rapid, from 120 to 150. With this type there is incessant cough, causing much pain to the little sufferer. In this form, if dyspnoea exists early, the prognosis is unfavorable. The rales are often found over the entire chest. I do not think I have ever gained much information by trying to percuss a child's chest. The ear, together with the character of the cough, respiration, and the expression of the face and color of the skin are the main symptoms from which I try to make a diagnosis.

The third type, the common type, as Holt puts it, is, in my opinion, fortunately for us, the most common, and sometimes I think it a little hard to differentiate it from ordinary lobar-pneumonia. The temperature in all the three types often runs high, but I have noticed there is a tendency in this type for the temperature to remit, which is fortunate for the patient, because during this remission it gives the patient time to recuperate somewhat.

If the symptoms appear in a very aggravated form you may see vomiting. I have seen convulsions in three cases, due I think to extreme high temperature. The marked symptoms are in addition to those already mentioned, temperature 101 to 106 degrees; respiration from 40 to 80, or even more. Cough common and incessant, disturbing rest and sleep. There is no expectoration. The mucus, if coughed up into the throat, is swallowed. I have seen children have several green stools a day, containing mucus and undigested food, due to gastro-intestinal weakness and functional disturbances. This symptom plays an important part in the treatment and prognosis. It is a condition which I dread very much. The urine is scanty and high colored. Delirium is quite common, especially with children from two to four years of age. The skin dry and hot. The eyes showing a glassy appearance and sometimes there is muscular twitching.

#### TREATMENT.

Unfortunately, the disease sometimes runs such a rapid and fatal course that

we fail to see any benefit from our treatment. First, empty the stomach and bowels thoroughly. To do this I usually give an  $\frac{1}{8}$  of a grain calomel combined with  $\frac{1}{4}$  grain sodium-bicarbonate every half hour until two or three typical stools appear. This followed in twelve to eighteen hours by syrup of figs as a laxative. If the pulse is hard and bounding I give Norwood's tr. veratrum in half drop doses every half hour for four doses, or until effect, then every two or three hours so long as necessary. If on the other hand, the pulse is soft and compressible I invariably give tr. aconite in one to two drop doses, with tr. bryonia also arom. spts. ammoniae in ten to fifteen drop doses every three or four hours.

To soothe and quiet patient, nothing is better than the old fashioned Dover's powder combined with a little pulverized camphor gum in sufficient doses to have the desired effect.

My treatment as to topical applications consists mainly of three procedures. If I use cotton-batted silk-lined jacket, I use an inunction of camphorated oil rubbed in thoroughly around entire chest. The jacket should open in front. Another local application of mine, from which I have had good results, is equal parts of glycerine and tr. iodine painted on the chest every five hours. My third local application, and one I am partial to, in which I have gotten good results, is a plaster of antiphlogistine applied well to the chest wall behind and in front. These applications aid in getting rid of the lung engorgement, a condition which often proves fatal. I do not believe I ever got much result from the administration of cough syrups, though I often use them as a vehicle for other remedies.

In the latter stages, two or three drops of turpentine dropped on a lump of sugar and given four times a day is beneficial. As to strychnine, digitalis, oxygen and the regular attention of a number of very scientific physicians, I think most cases of pneumonia will succumb under their constant employment. However, don't forget to use strychnine to sustain life. The hygienic treatment is one of the most important factors in the successful treat-

ment of this disease. The room should be large, well ventilated, with a temperature in the neighborhood of 70 degrees, and I much prefer open fire-places to the grate. Avoid cold draughts. The light should not be too bright nor too dark and dismal—a soft, mellow light lending cheerfulness. I rarely disturb a child from sleep to give medicine. The room should be kept quiet and absolutely void of any confusion or excitement. Nursing and the administration of medicine to children require a lot of tact on the part of the nurse. Kindness, gentleness and positiveness are the three essentials. As to stimulation, we should practice prudence and caution. I use stimulants when needed, but I do not use as much stimulation now as when I first began the treatment of this disease.

In conclusion, I desire to thank you very much for your kind and courteous attention. I hope the subject will be discussed freely, as it is one in which I am and have been very much interested.

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#### PUERPERAL FEVER.

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C. C. GAMBRELL, M. D.

ABBEVILLE, S. C.

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My principle object in writing this paper is to bring out a full discussion of the treatment of an infection that annually causes deaths in our country.

We have no other condition that causes a physician more anxiety than a severe case of puerperal fever, let it be a streptococcus, staphylococcus, or mixed infection. I am not going to divide the treatment into any specific classification, but give it to you as I generally proceed at the bedside of a patient. If when called to a patient, I am convinced that she has an infection, the first thing I try to do is to get rid of it, and that in the quickest way. If my patient has high fever, and the skin is moist and clammy, I order cold towels put to her head and her face and arms sponged off, also hot applications put to her abdomen. My first medicine to be given is either ten grains of calomel,



or one ounce of castor oil. The other medicinal agents used are strychnine and whiskey to support and stimulate the patient; quinine to increase the leucocytosis, and help decrease the temperature. Liquid diet and peptonoids to supply the great demand on the strength of the patient. If the patient is suffering much pain I will give a hypodermic of morphine and leave a few powders of codeine for her to take after the effects of the morphine pass off, for she will usually need an anodyne of some kind. In cases of sleeplessness, I usually give ammonol of sulphonal in ten grain doses. In cases where there is diarrhoea, I do not think it best to check it for in that way the system gets rid of a great deal of the poison, and I cannot recall a single case that has died where I had a diarrhoea to contend with, but in every case where I have attempted to check it, the fever has gone higher, and my patient has grown worse until the bowels were thoroughly opened up again.

The local treatment, I believe, is the most important thing in a puerperal case, and right here you must be strictly surgically clean. The first thing to do is to get a basin of water that has been boiled and in it dissolve two bicloride tablets, or add two teaspoonfuls of lysol or creoline. With this solution you should sponge off the labia and external vagina thoroughly, after which fill your fountain syringe with a solution of creoline, lysol, or bicloride and flush out the vagina; be sure to get away all clots and decomposing debris. Here I prefer to introduce a bi-valve speculum through which I pass my double current intrauterine douche tube, and use about two quarts of the antiseptic solution, or rather keep up the stream until it returns free from clots or debris. After giving this douche, if I have any reason to believe I have a portion of retained placenta to deal with I explore the uterus with my index finger, and if I feel any rough places or lumps, I take this instrument (McDade's Curette) and remove them, following the use of the instrument with another flushing with the antiseptic solution. My reason for introducing the speculum and pulling down

the mouth of the uterus is I can see what I am doing and not give the patient pain by putting the point of the douche tube in the anterior or posterior cul de sac and pushing it thinking I am entering the uterus, and another reason is it enables me to inspect the vaginal walls for possible pelvic abscesses, erosions, etc. I recall one case where I thought my trouble was in the uterus, but after cleansing my patient properly, I found I had an erysipelas of the labia majora and perineum to deal with which subsided very readily under treatment.

Now in reference to the serum treatment, I have used it in two or three cases, but did not see that it did any good. I do not think we should use the serums unless we have a bacteriological examination made of the lochia and know what bacteria predominate.

Credè's ointment I have used, but have not had any marked success with it. Some authors recommend opening up the anterior and posterior cul de sac and packing around the uterus with iodoform gauze. I have never tried this, but can readily see that it is a rational surgical procedure, and under favorable surroundings I would use it if all other treatment had failed.

As to transfusion to dilute the poison and the continual flow treatment, we will bring that out later as I have had no experience along that line.

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## DISEASES OF THE HEART.

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JOHN. B. BRITT, M. D.,

TROY, S. C.

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In diseases of the heart we, as practicing physicians and general practitioners, have especially to deal with diagnosis and treatment. The diagnosis of the diseases of the heart, of course, would require some degree of knowledge of its anatomy and physiology.

The heart is a hollow muscular organ employed in forcing blood into all parts of the body, and is stationed in the chest by the great vessels which spring from

its base, and by the attachments to the diaphragm of its membranous coverings—the pericardium. It lies obliquely in this membrane with its long axis directed downward and toward the left. Its broad end or base points backward and upward toward the right shoulder. The interior of the heart is lined by a serous membrane, the endocardium, which is reflected over the valves. These valves all lie in close proximity to one another and within a space of less than an inch square. In order to locate for the purpose of diagnosis the different portions of the heart it is well to mention the relative positions regarding the chest wall. The auricles are on a line with the third costal cartilages. The right auricle extends across the sternum to the right side of the chest. The right ventricle is placed under the sternum and partly to the left of it. Its inferior border is on a level with the sixth cartilage. The left ventricle lies within the nipple between the third and fifth intercostal spaces. The apex is situated between the cartilages of the fifth and sixth ribs to the inner side of and from an inch and a half to two inches below the left nipple. The size of the heart is about that of the closed fist.

The different methods which we should observe in the physical diagnosis are as follows: We should inquire into the history of the case; and into such symptoms as the expression of the face, appearance of the eye, the condition of the capillary circulation, the presence or absence of dropsical swelling, and of cough, the state of breathing, the character of the pulse, and the frequency and violence of the palpitation. The cardiac region must be scrutinized by the eye and by the hand.

The size of the organ is estimated by percussion and the sounds must be studied by a well trained ear, aided by a stethoscope.

#### INSPECTION.

Inspection detects on the chest of some healthy persons a slight protrusion over the seat of the heart, yet this is not constant or the general rule. When the heart is hypertrophied or when fluid has accumulated in the pericardium we can

notice a marked prominence in the praecordial region. The impulse of the heart is a very important sign in the heart disturbances. This impulse is seen right where the apex beats against the wall of the chest, about the interspace between the fifth and sixth ribs about an inch inward and two inches downward. In lean persons it is very distinct, and, of course, is not detected at all in some fat persons.

The alteration in the character and force of impulse are as diversified as those of its seat, but these alterations are more readily appreciated by the hand than by the eye.

#### PALPATION.

A few points on palpation. So far as the exploration of the heart itself is concerned, I prefer palpation to inspection. Many an impulse can be felt which cannot be seen. The rhythm of the motion is changed by quite a number of affections which may be functional or organic, so is the extent and force of the beat. Both are temporarily increased by powerful excitement, but both are permanently augmented by hypertrophy. When the hand is laid on the praecordial region it perceives at times two impulses, this double impulse is often recognizable in health especially in thin persons. But is more evident in hypertrophy with dilatation of the ventricles. One of these impulses is systolic, the other corresponds to the diastole; and if you find that the systolic beat is split or double it is evidence of praecordial adhesion.

Besides the impulse of the heart other phenomena may be studied by placing the hand over the heart. The fingers applied over the heart can perceive at times a peculiar thrill, or rubbing movement, first called by Laennec (from its resemblance to the purr of a cat) "the purring tremor," and is always indicative of a valvular lesion. The second is caused by the to and fro motion of a roughened pericardium. The cardioscope and the cardiograph have been used for close analysis of the cardiac impulse, but as yet have no real value for diagnostic purposes.



## PERCUSSION.

Percussion affords us the most ready means for judging the size of the heart. But percussion requires study, practice and skill. The dullness elicited by percussing the cardiac region is not so absolute as that of the liver, or of some other solids, nor is it the representation of the size of the entire organ, but simply portrays the more superficial portion which is uncovered by the lungs. It is, however, more difficult to define these limits in the case of women, but can be very well arrived at by pushing the mammary gland to one side while percussing, and very difficult in children on account of the space of dullness being very small. In cases of emphysema the area of dullness is diminished, but is increased by a shrinking of the left lung, also by diseases of the heart and its membranes.

## AUSCULTATION.

When the ear or stethoscope is applied over the healthy heart we can detect two distinct sounds of dissimilar character. The first is long, dull and heavy, and denotes the impulse against the walls of the chest; the second is short and flapping and occurs after the impulse. Clinical observation teaches that the sounds of the aorta are to be found at the right edge of the sternum about the second intercostal space.

The mitral is heard immediately above the beat of the apex. Such are the sounds which the healthy heart presents. Most usually the cardiac murmurs spring from a change at one of the orifices. This may be either narrowing, or a roughening, which interposes a local obstruction to the flow of the blood, or it may be an insufficiency to close the opening. In the latter case the blood regurgitates, and a murmur is occasioned by a deviation of the current and the establishment of another. Thus to sum up the subject we find murmurs which depend upon organic changes and murmurs which are not connected with any structural change, and thus inorganic. The latter murmurs are due either to an unnatural condition of

the blood, or to temporarily prevented action of the heart.

## PAIN AS A SYMPTOM.

Pain in or over the heart is met with both in acute and chronic diseases yet it is not a well defined symptom of either; but in acute affections of the heart, pain is a constant symptom. Actual pain is always a manifestation of inflammation of the heart substance itself or its membranes, and of all affections of the heart there is none so painful as angina pectoris.

## PALPITATION.

Palpitation is only a symptom and is present in various diseases of the heart. It is always present in the beginning of an acute attack, and is an unfailing accompaniment of some chronic lesions. Palpitation is often due to serious changes in the valves or in the muscular structure. The patient will tell you that he has a feeling of constriction about the heart, and that his heart jumps as if it would jump out of his body.

As pain, palpitation and irregular action are met with when there are no structural changes these conditions are known as functional disorders of the heart, and the symptom may be said to constitute the disease itself.

## FUNCTIONAL DISORDERS OF THE HEART.

Functional disorders are very much more frequent than the organic. They are for the most part produced by direct excitement of the heart, or by its being sympathetically disturbed by some source of irritation existing remote from it, or in the system at large. Thus a disordered stomach or liver leads to reflex disturbance of the heart which ceases if the disordered stomach or liver be remedied. I have known masturbation and excessive sexual indulgences, especially the former, to produce severe attacks of palpitation. In those who are subject to attacks of palpitation, or to irregular actions of the heart, there is no reason why the heart itself would not become enlarged; on the contrary there is decided reason why it should. Leyden pointed out a peculiar beat of the heart which he called a "hem-

isistole" in which the pulse was felt only once for every two beats, and he accounted for this peculiarity by saying that it is due to irregular contractions of the muscles of the heart. We sometimes meet with a singular form of disturbance of the heart which does lead on to textural excitement of the organ as evidenced by its increased force and rapid and irregular action which is followed by a swelling of the thyroid gland, pulsation of the arteries of the neck and prominence of the eye balls. This strange disease, exophthalmic goitre, is most commonly observed in females, and connected with hysteria, neuralgic or uterine disorders and is thought by some to be due to an affection of the cervical sympathetic nerve. In distinction from ordinary goitre the absence of the eye and heart symptoms are of most value. There is also no murmur heard over the enlarged thyroid gland, whereas in Grave's disease a continuous murmur is most common.

I have mentioned some of the principal varieties of functional heart troubles and we will observe that the physical signs present the most certain, if not the only, means of distinguishing the functional from the structural affections.

ORGANIC DISEASE OF THE HEART.

I shall only mention a few symptoms and signs of these maladies and shall not take up the anatomical classification. Acute diseases presenting pain in the cardiac region and symptoms of disturbed circulation and a change in the sound of the heart or the sounds replaced by murmurs. All the acute affections come under this head. In all the sounds are either changed in their character or are replaced by murmurs. Acute endocarditis is one of the most marked examples under the above mentioned head.

ACUTE PERICARDITIS

This is an acute inflammation of the serous membrane of the exterior of the heart; and is very similar to inflammation of the interior. So far as symptoms are concerned nature has not drawn a very strict line of demarcation.

The sound that we hear on auscultation

over the heart is like the crumpling of parchment, or the creaking of new leather. The percussion dullness due to the effusion is generally considerable and its contour is characteristic. Some of the main points for differentiating endocarditis from pericarditis are the following:

ENDOCARDITIS.	PERICARDITIS.
(1) Blowing sound with excited action of the heart.	(1) Friction sound with excited action of the heart.
(2) Slight increase of percussion dullness.	(2) In stage of effusion marked and extended percussion dullness.
(3) Impulse strong.	(3) Impulse wavy and feeble.
(4) Sounds normal or more distinct except at site of murmur.	(4) Sounds feeble and muffled except at base; no blowing sound.

There are so many forms of organic heart troubles, such as myocarditis, hypertrophy, dilatation, fatty degeneration, etc., that it would take up too much of your valuable time to give a differential diagnosis.

TREATMENT IN GENERAL OF VALVULAR DISEASE OF THE HEART.

Our first effort should be to promote and maintain perfect compensation if possible. The most important means to this end is to control the diet, also physical and mental activities. The diet should be simple, nutritious, easily digested, and the amount taken at any one time should be moderate and should consist for the greater part of nitrogenous foods. Sugar and starchy foods should be used very sparingly. Coffee should be indulged in very temperately, and if it seems to aggravate the already existing distress leave it off entirely. Mental strain, overwork, worry and excitement should be avoided as much as possible. In extreme cases where signs of failing compensation come on very gradually, and the patient seems to get worse slowly, I have found that complete rest in bed for about two weeks will do a great deal to restore compensation. As for a remedial agent when the heart action is feeble and ineffective digitalis used properly will give good results, especially I have found good results from digitalis in cases where there is considerable dropsy. I prefer to



precede a course of digitalis with mercury. Calomel seems to open up the arterioles better than any other purgative. I also find that digitalis gives good results, or the best results, if the patient would remain quiet in bed. I have found, also, that ascending doses of digitalis are of advantage. Increase the amount given until the heart's action is decidedly improved. Nausea, vomiting and decreased amount of urine are evidence that digitalis has been pushed to the point of tolerance. Strychnine is good to supplement other treatment, and is unquestionably a good general and cardiac tonic. Nitroglycerine is good to relieve cardiac distress and dyspnoea, especially when cyanosis exists. There are a great many useful remedies in the later materia medica, such as strophanthus, sparteine and many other new ones that I have tried, but after all I found myself drifting back to digitalis, strychnine and nitroglycerine. In regard to treatment of organic heart troubles I have nothing to say. My experience with all forms of heart troubles has been very limited and especially the treatment of the organic.

If I should have a case of illness that I would recognize as one of the acute organic heart troubles I would endeavor to treat the symptoms as they arise.

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#### ACUTE GLOSSITIS.\*

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R. G. HAMILTON, M. D.

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Gentlemen: I have chosen for my subject to-day a disease that is very rarely met with, Acute Glossitis, an acute parenchymatous inflammation of the tongue, sometimes ending in abscess. It is characterized by rapid onset, severe salivation, tenderness on mastication, followed by rapid swelling. The tongue becoming enormously enlarged protrudes from the mouth and is indented by the teeth. Temperature ranges from 100 to 101, rarely above 102.

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\*Read before the Spartanburg Co. Medical Association, Dec. 22, 1905.

*Etiology.* Predisposing causes are supposed to be an impaired general health and exposure to damp cold weather. Exciting causes are most frequently the stings and bites of insects, burns, scalds, mercurial stomatitis and, the action of corrosives. Anders says that many cases follow slight injuries to the tongue that allow the introduction of inflammatory poisons or microbes. Glossitis occurs more frequently in males, and more often summer.

*Symptoms.* These come on rapidly with more or less local severity and danger. The tongue becomes much swollen and may protrude from the mouth, is indented by the teeth, and is almost immovable, feeling heavy, painful, and tender. It is coated with a thick yellowish-white fur on the dorsum. Salivation accompanies these symptoms, speech is impossible, dysphagia extreme, accompanied by dyspnoea of more or less severity. The glands underneath the jaw are swollen. The temperature rises to 101, rarely above it. Death may occur in a few hours from suffocation, or after a longer interval from diffuse suppuration, gangrene, septic fever or pneumonia. Gangrene is more frequent than spontaneous resolution. If resolution is established the swelling begins to subside in three or four days. Small ulcers form on the tongue and by the end of a week its normal appearance is regained. The fever and distressing symptoms disappear with the swelling.

*Diagnosis.* Acute Glossitis must be differentiated from edematous swelling due to salivary calculus or affections of the floor of the mouth. Hemiglossitis sometimes occur. The local symptoms are not so great, as only half of the mouth is occluded.

Prognosis is favorable except that serious obstruction may remain. *Treatment.* When the case is seen early and during the congestive stage the topical use of ice allowed to dissolve slowly in the mouth is serviceable. Mucilaginous mouth washes containing some mild antiseptic should also be employed. A brisk saline laxative purge should also be given early. Should the tongue become alarm-

ingly swollen, deep scarification gives relief. Steam atomization, medicated, aids resolution. Abscesses, should they form, should be opened and washed with an antiseptic wash. Tracheotomy is rarely called for. Rectal alimentation if necessary. During convalescence any good tonic, light foods for a reasonable time. Remove any local irritant, as carious teeth.

The only two cases I ever saw occurred in my practice in the spring of 1904. Both cases were in males, in the same family, occurring only a few weeks apart. One of them had a very severe case—the other was mild. The weather was very rainy and cold. The severe case was a young man about twenty-nine years old, strong and healthy. The mild case was an old man about seventy-five years old. Both followed the course of typical cases. Both recovered with no after effects.

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#### APHORISMS.

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JOHN L. DAWSON.

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1. There is no pathological change in the brain or spinal cord, the symptoms of which might not be simulated in chronic uræmic conditions.

2. The educated sense of touch is more valuable in diagnosis than the educated sense of hearing.

3. Measles is more to be dreaded as a complication of pulmonary tuberculosis than any one other infection.

4. There are only three diseases which may present a remittent type of fever as their only symptom during their first stages, typhoid fever, tuberculosis and the aestivo-autumnal type of malarial fever. The latter can always be controlled by quinine.

5. Iodide of potassium is a renal irritant and therefore should not be given if there be a tendency to acute inflammation of those glands.

6. Intra-thoracic pain relieved by posture is almost sure to be due to pressure of some tumor; hence its diagnostic value in aortic aneurism.

7. The appearance of a few hyaline

casts in the urine does not necessarily mean organic disease of the kidneys; they may be due to simple functional disturbance.

8. Make your diagnosis as far as possible at the bedside, and then confirm it in the laboratory; clinical symptoms are far more reliable than chemical or microscopic findings.

9. The Diazo reaction in tuberculosis is a very bad prognostic, whilst in typhoid fever it has no bearing on the prognosis.

10. Faulty diagnosis due to superficial examination and hasty observation, is without excuse. (Nothnagel.)

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#### COUNTY NEWS.

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##### Abbeville.

The Abbeville County Medical Society met in Dr. C. C. Gambrell's office Feb. 2, 1906, and the following members answered to the roll call: Pres. F. E. Harrison, Vice-President J. A. Anderson, Secretary and Treasurer C. C. Gambrell, Drs. L. T. Hill, G. A. Neuffer, D. S. Knox, J. B. Britt and J. W. Wideman.

After reading the minutes of the January meeting, Dr. Britt read a paper on heart diseases which was discussed by every member present. At the conclusion of the discussion Dr. Neuffer moved that the paper be sent to the State journal for publication. Dr. Gambrell read a paper on the treatment of puerperal fever. This paper and its subject were discussed and every doctor present gave his method of treating this infection. This paper, by order of the Society, will be sent to the *Journal*.

Dr. Neuffer made a motion that the entire proceedings of our Society be sent to the *Journal* monthly, but this was objected to by the secretary on the ground that he was unable to get down all that was said in the discussions, and he thought it unfair to those who wrote short papers to have them published when the discussions were withheld for it was the object of most of the men writing papers to get a full discussion on that subject so that every one would profit by hearing the different methods in vogue described.

The Abbeville County Medical Society is doing good work. There are now only three doctors in the county who are not members, and it is hoped that they will join in a short while. All of the members take an active interest in the work, and the majority have written papers on subjects assigned them by the president. At the next meeting The Treatment of Wounds will be discussed. The paper on this subject will be read by Dr. Neuffer, President of the S. A. L. Surgeon's Association.

After the meeting, the Society adjourned to the hotel for dinner where an hour was spent discussing medical and non-medical subjects.



### Hampton.

A very enthusiastic meeting of the Hampton County Medical Society was held at Hampton on January 17th, for the purpose of electing officers to serve for the ensuing year, with the following result:

President, Dr. N. C. Johnson, Luray, S. C.; Vice-President, Dr. M. B. Monsen, Luray, S. C.; Secretary and Treasurer, Dr. C. A. Rush, Hampton, S. C.; Censors: 3 years, Dr. P. F. Bowers, Luray; 2 years, Dr. J. W. Colson, Varnville; 1 year, Dr. C. P. Walter, Crockettville.

At this meeting the Hampton County Board of Health was organized to act under the auspices of the Medical Society in about the same manner as the State Board of Health now acts under the State Medical Association. The object of this board is to stamp out all contagious diseases, especially small pox, and to be in a position to take hold and handle any kind of epidemic disease.

The society although not quite a year old is well organized. The majority of the qualified practitioners have joined and it is hoped that during the present year the name of every qualified practitioner in the county will be found on the roll.

Dr. F. J. McKinley has moved to Georgia, where he had quite a flattering offer made him by a saw mill company operating quite a number of hands. We are sorry to lose the doctor from our ranks.

At this meeting a resolution of thanks to the management of *The Journal* for the efficient service during the first six months of its career.

### Kershaw.

At the annual meeting of the Kershaw Medical Association on Jan. 9th, the following officers were elected to serve for one year. President, W. J. Burdell, M. D., Lugoff, S. C.; Vice-President, A. W. Burnet, M. D., Camden, S. C.; Secretary and Treasurer, S. C. Zemp, M. D., Camden, S. C.

Committees: Science and Progress, J. W. Corbett, J. T. Hay and W. J. Dunn. Grievances and Appeals, A. A. Moore, A. W. Burnet and J. W. A. Sanders. Finance and Printing, Burdell, Burnet, Zemp.

On January 24th a banquet was given at the DeKalb House, in honor of Dr. Lindsay Peters, of Columbia, S. C., who addressed the Association, reading a very interesting paper on gall stones.

### Union.

The Union County Medical Association is still alive, holding weekly meetings at which an original paper is read followed by a profitable discussion.

This society, at the request of the trustees of the graded schools, supplies a lecturer on practical hygiene to the advanced grades, each member being appointed in turn. Drs. J. H. Hamilton and S. G. Sarratt attended the meetings of the fourth district in Greenville and report that the Greenville members of the association maintained their reputation for hospitality.

All are now looking forward to the meeting of

the Tri-State Medical Association at White Stone on the 27th instant.

The officers for the present year are: President, Dr. Crown Torrence; 1st Vice-President, Dr. C. W. Austell; 2nd Vice-President, Dr. J. G. Goring; Secretary and Treasurer, Dr. S. G. Sarratt.

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### MARRIAGES.

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On Dec. 28th, 1905, at Greenwood, S. C., Dr. E. Marvin Dibble, of Marion, S. C., to Miss Alice Webb, of Greenwood, S. C.

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### OBITUARY.

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#### DR. BENJAMIN WALTER TAYLOR.

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At a meeting of the Medical Society of Columbia, S. C., held January 22nd, 1906, the following Resolutions were adopted by a rising vote:

The members of the Medical Society of Columbia wish to record their high appreciation and affection for their late fellow member and former president, Benjamin Walter Taylor.

Of distinguished lineage, a graduate from the best educational institutions of South Carolina, a devout adherent to her noblest traditions, he was for nearly half a century primarily and before other interests closely identified with all that concerned his profession in this community and State and section.

Of his worthy deeds in time of war, upon the battle field and in the hospital, none of us who are left may speak from personal knowledge, for he was our last Confederate Surgeon.

Although he filled with high credit many positions of trust and honor, yet it is rather to his virtues as a private citizen and as a general practitioner of medicine that we wish to pay especial tribute. While mourning our loss, it is for his example as an honest man, a tireless and self-sacrificing physician, a wise and resourceful consultant, an indulgent and faithful friend, and always as a Christian gentleman that each of us deems it a privilege to record his personal gratitude and pay reverent homage.

"His life was gentle; and the elements  
So mixed in him, that Nature might stand up  
And say to all the world: This was a man."

## NOTES AND REVIEWS.

## PRACTICE OF MEDICINE AND CLINICAL MEDICINE.

JOHN L. DAWSON, M. D.

## PATHOLOGIC PHYSIOLOGY OF TYPHOID.

Barach believes that the evidences of to-day are sufficient to establish the modern idea that typhoid fever is a disease dependent essentially on the bacteriemia. He thinks that the Peyer's patches and solitary follicles are not the sources from which typhoid bacilli are sent out into the circulation, but that their marked involvement is due to their peculiar histologic structure or to some physiologic relation that exists between the typhoid bacilli and the lymphoid elements. He also believes that perforation with the ordinary pyogenic infection, staphylococci and streptococci, is so much more dangerous than with the pathogenic infection, because to the latter there is already a partial immunity established, and that the diazo is a reaction to an end product, the result of rapid tissue destruction which is characteristic of all marked cases of typhoid fever, and of those other diseased conditions in which the reaction occurs.—*N. Y. Medical Journal*, January 13, '06.

## ONE-DAY PNEUMONIA.

Bechtold states that out of 1,057 cases of pneumonia at the Würzburg clinic, 10 were what might be called "one-day" pneumonia. The chill, high fever and crisis were observed in all, but the percussion and auscultation findings differed materially. The sputum was rusty in only one case, but traces of bright red blood were visible in another. Four of the patients were far from being robust, and these cases seemed to be due to a mild house contagion, all occurring close together in one ward.—*Münchener Med. Wochenschrift*, Munich.

## PREVENTION OF APPENDICITIS.

Tyson is of the opinion that careful regulation of the food, both as to quantity and quality, the manner of eating, the avoidance of constipation and a correct method of stooling are important factors in the prevention of appendicitis. He believes that the old-fashioned and natural method of defecating on the ground, with the thighs flexed on the abdominal walls, so that in straining the inguinal and femoral canals are practically closed, is made more conducive to the thorough emptying of the bowel, and therefore, less likely for obnoxious and poisonous materials to be left behind. The practice of kneeling down, bringing the buttocks in contact with the heels, and the anterior chest wall in contact with the thighs three or four times every morning, is a good and beneficial exercise, which he has practiced for some time past, and which he recommends to others.—*The Lancet*, London.

## VENESECTION IN SCARLATINAL UREMIA.

Singer advocates venesection as the most rational and beneficial measure in scarlatinal ure-

mia. It is especially indicated in cases showing symptoms indicating irritation of the brain. When there is a tendency to coma and depression, venesection can do no harm, but not much can be hoped from it at this stage. It is applicable to both robust and weakly children. If the pulse is filiform, the internal organs are generally irreparably injured at this stage and the operation is generally useless. Venesection should be done as early as possible, during the first uremic attack. The amount of blood to be withdrawn must be decided by the age, strength and severity of the attack. Venesection can be repeated at need after from twenty-four to forty-eight hours. Baginsky thinks that from one-fifteenth to one-twentieth of the total amount of blood can be let out without danger. In Singer's 17 cases of acute scarlatinal uremia treated by venesection, all the patients recovered but 2, that is, the mortality was 12 per cent. In the 9 cases treated without venesection the mortality was 56 per cent.—*Jahrbuch für Kinderheil Kunder*, Berlin.

## MATERIA MEDICA AND THERAPEUTICS.

J. L. NAPIER, M. D.

## THERAPEUTICS OF LOBAR PNEUMONIA.

Brem contributes a paper on pneumonia to the *Johns Hopkins Hospital Bulletin* for October, 1905, and in closing presents the following summary of the therapeutics of the disease:

1. Elimination of the toxic agent. Internal hydrotherapy.
2. Amelioration of harmful influences: (a) Fever—external hydrotherapy; pain—ice-bag and analgesics; restlessness, insomnia, delirium—external hydrotherapy, analgesics, and narcotics. (b) Respiratory indications: (1) Heroin or morphine every two hours for a respiratory-rate of 36 or greater; (2) oxygen inhalation is probably useless and may be harmful. Circulatory indications: (1) Circulatory sedatives are probably contraindicated, excepting the nitrates, which may be of benefit during early periods of increased cardiac work. (2) Alcohol indicated in alcoholic cases; may be of benefit when there is no circulatory insufficiency. (3) Circulatory stimulants contraindicated, except members of the digitalis series. The indication is low blood-pressure associated with one or more of three conditions, namely, respiratory insufficiency, small urinary output, edema of lungs.—*Exchange*.

## SODIUM GLYCOCHALATE IN DISEASES OF THE LIVER.

Richardson tells us in the *New York Medical Journal* of September 30, 1905, that glycocholate of sodium is indicated in all diseases in which toxemia is a factor, and, with few exceptions, where hepatic insufficiency exists. In many cases of malnutrition, from want of proper absorption of fats, it will materially aid in building up a patient. Above all it is indicated in hepatic colic and gall-stones—in the former it is almost a specific; and in chronic constipation combined with the "purgative habit" it is of great value. The



dosage is about 5 grains three times a day, though as much as 15 grains may be given without producing nausea. As the action of the drug is cumulative owing to its resorption from the intestine, it is not necessary to keep up the full dose for any great length of time. In hepatic colic it is advisable to continue the administration for some months. The patient should take about four drachms a month, regularly, as a prophylactic. In all forms of hepatic insufficiency sodium glycocholate is indicated as a hepatic stimulant in conjunction with other treatment. In arterial sclerosis, in conjunction with the administration of the inorganic salts of the plasma in their proper percentage, it dissolves the cholesterol in the atheromatous deposits, while the salts mentioned tend to dissolve and to prevent the deposit of the calcium salts. In diabetics, when increased absorption of fats is necessary to replace the loss of carbohydrate; and in tuberculosis, in which fat hunger is a pronounced symptom, Rousel alleging the fat hunger is an etiological factor, sodium glycocholate is indicated.—*Exchange*.

#### THE AFTER-TREATMENT OF DIPHTHERIA.

In a paper contributed to the *Journal of the American Medical Association* of October 21, 1905, White tells us that the after-treatment of this disease consists in a sufficient period of rest in bed, and then in watching the effect of mild exercise on the heart for several months at least, and grading it to meet individual requirements. Tonic drugs, such as strychnine and iron, are occasionally useful.

All the severe cases require rest in bed and careful watching of the heart for months or years afterward.

White concludes that:

1. The cardiac disturbance after diphtheria, usually presents the picture of a mitral insufficiency with irregular heart action and few symptoms. Occasional cases have rapid pulse or cardiac irregularity without any other signs.
2. Moderate disturbance of the heart is very common after diphtheria, and in a large number of cases persists from two to six months after the original illness.
3. In many cases the cardiac lesion does not clear up in the first half year, but lasts much longer; some ultimately recover; others probably do not. The duration of the heart trouble is usually in proportion to the severity of the original illness.
4. The fact that children often have few heart symptoms after diphtheria must not mislead us as to the importance of the injury to the heart.
5. Cardiac disturbance of long duration following diphtheria may be entirely recovered from. It is not necessary to give up hope of recovery in individual long cases.
6. The treatment of this condition consists in a sufficient period of rest in bed, and then in watching the effect of mild exercise on the heart for several months at least and grading it to meet individual requirements.—*Exchange*.

#### A NEW HYPODERMIC FORMULA FOR CAMPHOR AND CAFFEINE.

*La Press Medicale* of November 1, 1905, states that Claret has found the following formula very advantageous:

Caffeine  
Salicylate of Sodium, aa grains 4;  
Distilled water, minims 15.  
Mix thoroughly and add of  
Spirit of Camphor (10 per cent.),  
minims 15.

It is asserted that this formula remains clear for a long time.—*Exchange*.

## OBSTETRICS AND PEDIATRICS.

LANE MULLALLY, M. D.

#### ECTOPIC GESTATION.

W. H. Randle (*American Medicine*, Jan. 20, '06,) contends that often in fatal cases death is not due to heart disease as is usually supposed, but is really due to internal hemorrhage from ectopic gestation. He says when in doubt concerning the diagnosis, that it can be easily verified by making a small vaginal incision through the posterior vaginal vault when the escape of free blood will prove the diagnosis. The treatment after this is operative. Randle recommends using as small amount of anaesthetic as is possible and no stimulation until the bleeding point can be found and secured. That when the opening is made through the abdomen, do not stop to consider the large amount of blood found, but place the hand at once on the ruptured tube and grasp with forceps the bleeding points. After the bleeding points have been secured then employ stimulants. Remove all blood clots and flush the cavity of the abdomen with sterile saline solution. Drainage is more harmful than necessary. In all cases where a hematocele has formed the clots may be removed through a vaginal incision but the patient should be ready for laparotomy as hemorrhage is liable to recur.

#### UTERINE INERTIA AND ITS MANAGEMENT.

Brodhead (*New York Med. Jour.*, January 13, '06,) in an article under the above title outlines the treatment of postpartum hemorrhage. He administers ergot by the mouth as soon as the contents of the uterus have come away. If hemorrhage is alarming he gives ergot hypodermically and keeps up continuous massage of the uterus. He finds that a hot douche of normal salt at a temperature of 116 F. will as a rule check bleeding. If this does not check the hemorrhage, he gives an intra-uterine douche of the same solution at the same temperature. Should this not arrest the hemorrhage, he recommends Squibbs 80% acetic acid. Two ounces of this added to three quarts of water makes the proper solution. Should this not check the hemorrhage, he tampons the uterus with either a 5% iodoform gauze, or plain sterile gauze. If the gauze is not at hand he recommends the introduction of a piece of ice in the cavity of the uterus which generally produces uterine contraction.

## SURGERY.

T. P. WHALEY, M. D.

### BAZY'S URETHROTOME.

After an excellent article on "The results of Internal Urethrotomy with Bazy's Measuring Urethrotome, based on Forty-Two Cases," F. Joly concludes that the principal reproach that may be made against the various Urethrotomes in general is the impossibility or difficulty of exactly measuring the stricture and consequently the risk that one runs of cutting the healthy portions of the Urethra. With Bazy's instrument one can exactly determine the seat, length, calibre and number of strictures. His urethrotome, contrary to that of Maisonneuve, will only cut the stenosed tissues and respects the healthy parts. No hemorrhage occurs, although three incisions are made, because fibrous tissue alone is cut. It allows one to introduce a sound of quite large calibre, generally No. 16 Charriere and in almost all the cases operated on the increase in calibre of the urethra obtained has been quite sufficient without any danger of recurrence.—*Amer. Jour. Urol.*, Dec., 1905.

In an excellent article on Amputations below the knee, Dr. C. B. Clapp, in the *Jour. A. M. A.*, Feb. 10, '06, calls attention to a few important details which we should not lose sight of, as follows:

1. Be certain of sufficient flap to properly cover the end of bone, regardless of how close this may come to the knee joint. Flap must be considered first, length of stump second.
2. The most uniform good results are obtained by making the long anterior with short posterior flap, bringing the scar well away from end of stump.
3. Redundancy is always undesirable.
4. When the length of stump is at the discretion of the operator, it should be from six to nine inches below lower border of patella.
5. Periosteal flap with coaptation of muscles over end of bone is always desirable.
6. Always cut the fibula one inch shorter than the tibia and when the amputation is near the knee joint, disarticulate and remove the fibula.
7. In all these amputations, nerves should be drawn out and cut as short as possible.

### ETIOLOGY OF SYPHILIS.

S. Flexner hopes that the cause of syphilis has actually been discovered. Many problems have hitherto failed of solution because observation has been limited to man, but the discovery that the higher apes are subject to inoculation points a new direction for experimental study. The use of these animals has already answered partly certain questions relating to the manner of entrance of the virus into the body and the comparative virulence of different products of the syphilized animal. It has been ascertained that the poison is easily injured or destroyed by low degrees of heat. Glycerin does not deprive it of its power. An unglazed filter which will permit the passage of the microbe of pleuropneumonia of cattle holds back the virus of syphilis. The evidence all points to the microbe being microscopic, not ultramicro-

scopic. *Spirochæta pallida* of Schaudin and Hoffmann is not actively mobile, and its tenuity and refractoriness to staining agents render it difficult to see. The flood of confirmatory publications on their discovery has created a faith which the discoverers have never publicly expressed. It has been found with striking constancy in the primary and secondary lesions of acquired syphilis, whether on the surface or embedded beneath the skin. It is possibly only an occasional and accidental inhabitant of the general blood stream, but there is abundant evidence of its distribution by the circulation. The evidence indicates that the spirochæta survives in the body for many years and is transmissible by a parent herself free from the usual signs of the disease. Examinations of infants with congenital syphilis show that the pallida is regularly present. Tertiary syphilids have been studied with negative results. Infection from a suckling child is explained by the occurrence of the germ in the pharynx.—*Amer. Med. News.*

## LARYNGOLOGY AND RHINOLOGY.

W. PEYRE PORCHER, M. D.

In recent rhinological literature occur the usual number of articles on sub-mucous resection of the septum and other operations and refinements of operations for corrections of septal deformities. In some instances an apparently endless number of instruments and paraphernalia are advised. The same rule may be applied to these operations as has been applied to others, namely that the success of the operation is due more often to the operation than to the kind of instruments used. In the writer's hands the long trephine for tunneling a hole through an obstructed nostril has proved to be an invaluable instrument. After the canal has been opened the removal of other obstructions becomes a comparatively easy matter. The difficulty generally comes afterwards—that is to keep the opening clear to prevent adhesions. This is especially the case when a patient has been for a long time accustomed not to use one nostril. In that case the patient rapidly relaxes into his old habit of not using the nostril and closure promptly follows.

Dupu, of New Orleans, reports cases of hemorrhage following removal of pharyngeal tonsil. Most of these were due to hemophilia, and some to abnormal arterial distribution. Twenty-seven cases in all are collated. Internal administration of chloride of calcium is recommended as a preventive. The dose should not exceed grs. 30 for the initiative dose and grs. 5 every hour until five or six are taken, because if too much is given the blood loses its coagulating properties. Adrenalin, peroxide of hydrogen, etc., are recommended as hemostatics.

Wainwright used anti-streptococcic serum with success in a case of streptococcus infection of the bladder with pneumonia and severe earache. Otto Neen reports a case of acute bilateral middle ear suppuration, following an intra nasal operation and resulting in death from pyemia. Anti streptococcic serum might have been used with success in this case, but in the experience of the writer infection following these operations is very rare.



## CAUTERIZATION OF THE NASAL MUCOSA AND THE PAROXYSMAL NEUROSES.

Francis Hare (Brisbane)—*Austral Med. Gaz.*, Melbourne, May 20, 1904.

Considering its source, this paper contains statements sufficiently startling to restore (if they prove correct), a good deal of the old time prestige of the cautery as used in the nasal fossa.

Hare states that: "We are indebted to Dr. Alex. Francis, late of Brisbane, for what seems to me, the most important of the advances which have been made in the practical therapeutics of asthma." Francis thus described his technique:

"After painting one side of the septum nasi with a few drops of solution of cocaine and resorcin on a pledget of cotton wool attached to a probe, I draw a line with a galvano-cautery point from a spot opposite the middle turbinated body, forwards and slightly downwards for a distance of rather less than half an inch. In about one week's time I repeat the operation on the other side, and afterwards do it on alternate sides at intervals of ten days or a fortnight, as occasion requires. On each occasion I select a fresh spot to cauterize."

Hare goes on to state that the results of this practice, including cases treated by Dr. W. N. Robertson of Brisbane, are as follows:

Complete relief .....	313 cases.
Great improvement .....	143 cases.
Slight or temporary improvement....	40 cases.
No improvement .....	24 cases.

Hare remarks that undoubtedly the first sentiment these figures tend to arouse is one of skepticism, but that those medical men who are personally acquainted with Dr. Francis, more especially those who have lived and worked in the same city, and who have seen and followed up many of his cases, would not, he thought, hesitate to accept his general results. The full rationale of the result is obscure. Francis soon found himself forced to abandon the view that the cautery destroys the sensory irritation in the nose which is the starting point of the reflex action, "because among other abundant and convincing evidence, as a rule, the quickest and most satisfactory results were obtained in cases where the nose was apparently normal." He considers that "asthma depends absolutely upon an unstable condition of the respiratory centre," that some part of the nasal mucous membrane has a controlling influence upon the respiratory centre," that "the area is situated on the septum nasi;" and that cauterization of this area is capable of restoring the stability of the respiratory centre.

Hare, however, prefers for the present to suppose that cauterization of the septum nasi has a restraining influence upon the "pathological vaso-motor action which constitutes the mechanism of the asthmatic paroxysm. \* \* \* If asthma is a vaso-motor neurosis \* \* \* and constitutes but one member of a long series of vaso-motor neuroses, more or less allied, then \* \* cauterization, it seems, should be widely extended as a therapeutic measure."

Hare quotes cases of Dr. W. N. Robertson demonstrating complication of angina pectoris with asthma, both relieved by cauterization of the septum nasi. He also quotes two cases of epilepsy complicated with asthma, in one of which the cauterization cured both, and in the other much relieved both diseases.—*Eaton*.

## OPHTHALMOLOGY AND OTOTOLOGY.

EDWARD F. PARKER, M. D.

## HEADACHES DUE TO OCULAR DISORDERS.

The subject of headaches and the frequency with which they are due to errors of refraction, intra ocular disorders and in-coordination of the extra ocular muscles is reviewed in a series of interesting articles in the Jan., '06, number of *Ophthalmology*. Wilkinson treats the subject historically, Lucien Howe clinically, and H. F. Hansell symptomatically.

S. Weir Mitchell is quoted by Wilkinson as follows, "What I desire, therefore, to make clear to the profession at large is:

(1) "That there are many headaches which are due indirectly to disorders of the refractive or accommodative apparatus of the eye.

(2) "That in these instances the brain symptoms are often the most prominent and sometimes the sole prominent symptom of the eye trouble, so that while there may be no pain or sense of fatigue in the eye, the strain with which it is used may be interpreted solely by occipital or frontal headache.

(3) "That the long continuance of eye trouble may be the unsuspected source of insomnia, vertigo, nausea, and general failure of health."

Howe writes, "If we ask, finally, what are the symptoms which can be referred to eye-strain, we can safely include in that list those in the three groups first mentioned—namely, symptoms referred to the eyes, to the head in general, or the stomach. Other morbid conditions may be dependent upon eye-strain, but proof of that is what we need, and not simply the affirmative evidence, but the negative evidence—the control observations."

Hansell writes, "No thoughtful medical man can be pessimistic concerning the value of careful refraction work. Since the announcement in 1869 of the discovery by Thompson that uncorrected errors of refraction and presbyopia were responsible for headache and obscure nervous symptoms was the commencement of a new era for oculists and for suffering humanity, his teaching has been recognized and followed and its benefits are incalculable. But while refraction work is the most important function of the ophthalmologist, the practice of ophthalmology embraces diseases of the eye and its adnexa both in their purely local manifestations and as symptomatic of general disease."

## BACTERIOLOGY OF EYE INFECTION.

Smith, Dorland, Bridgeport, Conn., (*Archives of Ophthal.*, September, 1905,) reports the results of bacteriologic examinations in a second series of one hundred cases of infection of the eye and mentions the therapeutic agents most effective in the treatment of the various forms of infection. Of sixty-five cases of conjunctival infection, fourteen were caused by staphylococcus, six by gonococcus, six by the diplobacillus. In the remaining twenty-seven cases no one organism was especially prominent. Of the ten corneal cases, the streptococcus was found in four, the staphylococcus aureus in two. Of ten lacrimal cases the pneumococci and streptococci

were found in seven. In ten cases no organisms were found."—(*Abs. W. R. M.*)

#### EXCESSIVE PIGMENTATION OF THE HUMAN EYE.

Anomalies. Excessive Pigmentations of the Human Eye. Schein, Albert. (From the eye clinic of Prof. E. Fuchs, Wein, Beitrag Zur Augenh., 1905, No. 64, p. 249.) Excessive pigmentations of the human eye are not very frequent. Generally these excessive pigmentations are considered congenital. Since, however, they have never been described in the new born, and normal pigmentation of the iris develops in the first two or three years of life, or the skin of the negro from the sixth week on, or gradually increase in size and color, Schein is inclined to surmise that probably the excessive pigmentations of the eye do not exist, or show only traces at birth and assume more intense forms in the course of years.—(*Abs. C. Z.*)

#### FUNCTIONAL DISORDERS OF THE EYE ASSOCIATED WITH PUBERTY.

Eye Defects Associated with the development of Puberty. Wheelock, K. K. Fort Wayne, Ind. (Medical Record, Oct. 21, 1905). The writer refers to L. Webster Fox's paper on "Contraction of the Visual Field, a Symptom of Anesthesia of the Retina in Children," which appeared in the *Journal of the A. M. A.*, for January 7th, 1904, and gives the history of a number of cases resembling those reported in the paper referred to. These cases all had (1) defective vision for distance and reading, (2) limitation of field for form and color, (3) no changes in the fundus, (4) age from 8 to 10 years, (5) absence of chlorosis or hysteria, (6) blood examination showing leucocytosis, (7) complete restoration of sight and field occurring only after the establishment of the menstrual function in the female and the seminal function in the male. The writer explains the phenomena by changes in the optic nerves and blood stream incidental to the development of the reproductive organs. The treatment which he found most effective was the use of iron, strychnine and manganese.—(*Abs. C. H. M.*)

#### THE TREATMENT OF ACUTE OTITIS MEDIA IN GENERAL PRACTICE BY A GENERAL PRACTITIONER.

In an article entitled "The Treatment of Acute Otitis Media in General Practice by a General Practitioner," by Wainwright, *Laryngoscope*, '06, he says, "In young children pain in the ear is fairly common, and its prompt treatment is a necessity. The proximity of the dura mater to the middle ear in infants, and the unjoined suture, must always be borne in mind. Charity covers a multitude of sins, but the maternal diagnosis of teething covers a large area, and frequently includes earache from adenoids and naso-pharyngeal troubles, not to mention the results of bad feeding. Otitis media derives much of its difficulty and uncertainty from being a secondary disease."

And later: "Citing a simple case of pain, hyperaemia, loss of hearing, we would apply cocaine and adrenalin to the tympanum; counter irritation at the back of the ear (mustard leaf or leeches); disinfect naso-pharynx with peroxide of hydrogen or iodine inhalation; inject medicated air or medicated oxygen through the nos-

trils; give a calomel purge, and keep patient in an even temperature."

Shambaugh, *Laryngoscope*, January, '06, writing about a case of Vicarious Bleeding from the External Auditory Canal, concludes as follows: "Gradinigo points out that a distinction should be made between bleeding from the canal which occurs in the presence of a trauma or a growth in the ear and bleeding that occurs when the canal appears to be quite normal. It is this latter that Gradinigo would consider as alone the true vicarious bleeding. In the case that I report here the fact that the swelling in the canal appears to be covered with normal skin and the appearance of the bleeding at the time of the menstrual flow, which it in part or completely supplants, leads me to consider this a case of true vicarious bleeding from the eternal canal."

#### EARACHE.

In *Medical Record*, January 20, '06, (*Abs. Jour. A. M. A.*, February 3, '06.) Bardes says that "as soon as earache begins the patient should be kept quiet, put to bed and placed on a fluid diet, and in other ways treated as one would treat a patient with high fever. The bowels should be kept open and a single dose of morphine, he states, may be given to insure rest and comfort. Dry heat or else an ice-bag can be applied to the ear. The former is more acceptable to most patients. Every three hours the ear should be gently irrigated with a hot solution of bichloride 1 to 5,000, after which a few drops of a twelve per cent. solution of carbo-glycerin can be instilled. Under no consideration should a person be allowed to suffer pain longer than twenty-four hours. If the pain continues, and the drumhead is inflamed and distended, palliative measures are worse than useless, and any attempt to abort the inflammation by means other than surgical is dangerous, and valuable time is lost in so doing. A bulging drumhead should be treated in the same way as a septic formation in any other place. It should be freely incised, rather than simply punctured or allowed to break."

#### BOOK REVIEWS.

THE PRACTICE OF MEDICINE. A text book for practioners and students with a special reference to Diagnosis, and Treatment, by James Tyson, M. D., Professor of Medicine in the University of Pennsylvania; and Physician to the Pennsylvania Hospital, Fellow of the College of Physicians of Philadelphia, Member of the Association of American Physicians, etc. With 240 illustrations, including colored plates. P. Blackiston's Sons & Co., 1012 Walnut Street, Philadelphia, Pa., Publishers. Price in cloth, \$5.50.

The Fourth Edition of this work, thoroughly revised and enlarged, is a neat volume, in attractive paper, and



printed in nice type. Over sixty additional pages of new matter have been incorporated.

The author tells us in his preface that the most important changes will be found in the section on Animal Parasites, which has been revised by his colleague, Dr. Allen J. Smith. This section is thoroughly and completely written, giving an accurate description of the Animal Parasites and the conditions caused by them.

Starting with a description of the Protozoa, a complete classification is given, which includes five classes with their various sub-orders. The substance matter is well written, clear, concise, and to the point, making valuable information for those who are especially interested in this part of medicine; besides giving a practical knowledge of these subjects to the general practitioner.

Starting with the lowest form of animal life the author takes you through a series of extremely interesting pages, easily understood, and profusely illustrated with cuts of the various forms of animal parasites, concluding the section with a description of the arthropods.

The rest of the work is fully in keeping with the previous excellent editions. Typhoid fever and the other infectious diseases are considered in the first part of the work, and in treating of the various diseases, particular attention is paid to diagnosis and treatment.

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#### MISCELLANY.

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##### The County Society.

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Organizations and institutions, like individuals and species, are subject to change and development. Like individuals they grow and conform to environment. This growth is not only an increase in size; it involves a change in form and function. It is no more reasonable to expect that the medical organization of to-day should be the exact prototype of that of our fathers than to expect that the man should have the physical appearance, the voice, the walk and the manner of the boy from which

he grew. The medical society of former days was a gathering of physicians mainly for the purpose of hearing and discussing papers prepared by their own members. Weekly, monthly or quarterly, the meetings were held, and after adjournment the society was forgotten or was at least in a state of suspended animation until the next regular meeting. In those days medical colleges were few. Post-graduate courses, except in foreign lands, were almost impossible, and then only at great expenditure of time and money. Medical journals were few and expensive. The medical society afforded the busy practitioner the only opportunity of voicing his experiences, his errors, his successes and his doubts. With a comparatively sparse and scattered population and few well-trained physicians, all of whom were engaged in the same line of work, there existed a condition of affairs vastly different from that of the present age.

To-day, with two-thirds of the country densely populated and the rest being rapidly settled, entirely different conditions exist. Medical journals, books and monographs are far more plentiful. Post-graduate courses are attended with comparative ease; specialism, due to the enormously broadened field of medical activity, has created interests which are apparently at least, diverse. Any physician in the land, no matter how remote, can have access every week to the best in current medical literature. The growth of medical science has well-nigh eliminated some diseases formerly common, and has also greatly increased the duties and responsibilities of the profession to the social body. Better preliminary training and more scientific educational methods have almost abolished the sectarian lines of the past. The educated physician of to-day has duties and responsibilities to society as well as to his individual patients.

From this it follows that the medical society of past years, with its occasional meeting for purely personal improvement, is to-day inadequate. The modern physician has a wider field than his own personal *clientele*. The ideal medical society of to-day has opportunities and duties far

wider than the professional organization of thirty years ago. It must be, as formerly, a meeting-ground for the exchange of the ideas and the experiences of its members, but it must be something more. It must be, in the true sense of the word, an organization. Organism implies functional activities. The more complex the organism the greater are the functional possibilities. The ideal county society of to-day is one which embraces all the reputable medical men in its territory. Its first duty is self-preservation, since all organisms must exist before they can functionate. This involves protection from dangers, both internal and external. Internal protection includes, as a prophylactic measure, the maintenance of a high intellectual and moral standard as a requisite for membership and the establishment of such a system of procedure as will conserve the self-respect and dignity of each individual member; consequently those rules of gentlemanly professional conduct, commonly called the principles of ethics, have been formulated. It, therefore, becomes the duty of the society having adopted such a principle to exert its authority and influence in enforcing it fairly, impartially and judicially. Under external dangers is involved the protection, by the united weight and power of the society, of its individual members against imposters and those who seek to prey upon them. The application of this principle justifies the society in taking up, investigating and, if advisable, legislating upon such questions as free dispensaries, lodge and contract practice, as well as providing for the systematic defence of its members from unjustifiable suits for damages. These questions have been dealt with by some of the more advanced societies in a manner eminently satisfactory to their members and with great increase in the influence and effectiveness of the society.

But an organization must have some work besides self-preservation. Its only

reason for existence is the good it may accomplish. It has a twofold obligation: first, to its members; second, to those outside its ranks. To its members, the opportunities for benefit are unlimited. The society should be a constant stimulus and aid to each member, helping him to make of himself the best and most useful physician which he is capable of being. By papers and discussions, clinical meetings, lectures, demonstrations, establishment of reading rooms, journal clubs, medical libraries, laboratories and hospitals, in some one of many possible ways each society can aid its members to improve themselves. To the laity the society can be of the greatest service. In the county or town in which it exists it should be, through its officers, the recognized authority on all matters of public sanitation and hygiene. Water supply, sewage, food and drink adulteration, tenement-house and factory inspection, child labor, school inspection, these and many similar topics can all be investigated, acted upon and in time practically controlled by a society of live, up-to-date, active physicians. As the public sees the wisdom of the society's recommendation it will soon learn to refer to the authoritative mouthpiece of the local profession all the questions which arise which have a medical or scientific aspect. If the society acts wisely, cautiously and fairly, its right to settle all these questions will soon be recognized.

This is not a vision, but an actual possibility. There are in existence to-day medical societies which are exercising all of these various functions. It is possible for the county society of ten or fifteen members to be alert, public-spirited and useful. It is also possible for the city society of hundreds of members to be lethargic and unprogressive. It is not a question of size or location, but of desire and earnest effort. Each society will be exactly what its members make it. If each member bears ever in mind his duty to his profession, his neighbors and his country, he will find that the ways are well-nigh unlimited by which the local medical society can be made of value to the individual and the community.—*The Councilor's Bulletin*, Jan. '06.



## CHRONIC ACETANILID POISONING.

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That chronic poisoning from acetanilid is not uncommon is evident from the numerous cases that have been reported recently. In this issue is the report of a case by Herrick and Irons, in which the absorption of the drug was from an ulcer of the leg, to which the remedy had been applied almost daily for seven years for its analgesic effect. In this respect this case is a rarity, but it warns us that care should be exercised in the use of this drug in dermatology or as an antiseptic in surgery. Points of interest in connection with the chemistry of the urine in chronic acetanilid intoxication are also referred to in the article, but what is of most value, at least to the general practitioner, is the grouping together of the phenomena of this form of poisoning, making of it something like a clinical entity.

According to Herrick, the acetanilid habit is to be suspected in a patient who presents a secondary anemia, cyanosis, dyspnoea, nervousness or gastrointestinal disturbance without an adequate explanation for it in heart, lungs or other organs. Splenic enlargement is not uncommon. The crucial test is the examination of the urine. This is commonly dark in color, it darkens still more on standing and contains an increased amount of conjugate sulphates and also paramidophenol. The general practitioner, although he may not be a chemist, need not feel that the examination of the urine in such cases is beyond him, for, as will be seen by consulting this article, the test for paramidophenol is simple.

If some of the obscure cases of neurasthenia, anemia, dyspepsia, etc., were more carefully examined, we believe an explanation for them would not infrequently be found in the acetanilid habit, the drug being taken either as such or as one of the ingredients of the many headache remedies and painkillers so easily obtainable at the drug store, and so often prescribed unknowingly by physicians.

The reports of such cases cannot fail to have a wholesome influence. They stimulate to greater thoroughness in fer-

reting out the existence of this habit, lead to greater caution in the prescribing of this remedy, which, when improperly used, is so potent for evil, and encourage us all in our efforts to combat the manufacture, sale and use of the many nostrums that contain this really dangerous drug.—*Journal A. M. A.*

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## THE RELATION BETWEEN PHYSICIAN AND PHARMACIST.

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There is a mutual dependence of pharmacy and medicine on one another: The doctor needs the pharmacist and the pharmacist can't get along very well without the physician. There is no antagonism between the honest pharmacist and the honest physician. On the contrary, there are few physicians who do not have especially close relation with some druggists with whom they frequently consult on pharmaceutical matters. In the propaganda for honest pharmacy as against secrecy and fraud in drugmaking the pharmacist is very much interested—certainly as much so as is the physician. Consequently the drug journals have had much to say about the Council on Pharmacy and Chemistry and its work. Some of these journals have jumped to the conclusion that there would be more money for them in siding with the nostrum makers, but the better journals, those which are recognized as representing scientific pharmacy—and these, we are glad to say, are in the majority—have seen in this movement a promise of better things, and a return to legitimate pharmacy, and have heartily endorsed the movement. Among the latter is the *Druggist's Circular*, of New York, a journal that for nearly fifty years has been recognized as representing the best interest of pharmacy. For years it has been fighting against the growing tendency toward the commercializing of the drug store, which has made pharmacy a mere incident to the business, and the compounding of prescriptions a side issue—the nostrum prescribing doctor being to blame for the latter condition. In the past the *Druggist's Circular* has exposed more

fraudulent nostrums than any other drug journal, and it is still courageously carrying on the work. It has now to fight a \$50,000 libel suit brought against it by a German chemical company because it dared to publish what it believed to be the truth. This leads us to suggest that the average physician will find in a good pharmaceutical journal—not a trade drug journal—many hints and suggestions about drugs and prescribing that will be most valuable to him. Not only this, but if he were reading such a journal he would be able to see himself as he is seen by the man behind the prescription case, which sometimes would be advantageous to both. He would see himself severely criticised occasionally—often justly so—and this would be a good thing.—*Journal A. M. A.*

#### AFFILIATED COUNTY SOCIETIES WITH MEMBERS AND NOTICE OF COMING MEETING.

The fifty-eighth annual meeting of the Association will be held in Columbia, April 18th, 19th and (if necessary) 20th, 1906. The Secretary is ready to receive the titles of papers to be presented at the meeting. The titles of these papers will form a part of the preliminary program, which will appear in the March issue of this journal.

As this list of Affiliated County Societies with members will appear in the March issue for the last time before the Association's annual meeting, and as it is important for it to be as complete as possible, the Secretary earnestly requests the County Secretaries to carefully revise their respective roll of members as it appears in this issue and forward it with corrections, if any, to him before the 10th day of March.

#### ABBEVILLE.

(ABBEVILLE COUNTY MEDICAL SOCIETY.)

*Secretary, C. C. Gambrell, Abbeville.*

J. A. Anderson.....Autreville.  
J. R. Bell.....Due West.  
P. R. Black.....Mt. Carmel.

J. B. Britt.....Troy.  
J. M. Carlton.....Mt. Carmel.  
C. C. Gambrell.....Abbeville.  
F. E. Harrison.....Abbeville.  
L. T. Hill.....Abbeville.  
J. W. Keller.....Abbeville.  
T. O. Kirkpatrick.....Lowndesville.  
D. S. Knox.....Autreville.  
Frank Lander.....Williamston.  
S. Mare.....Anderson.  
G. A. Neuffer.....Abbeville.  
W. H. Pepper.....Anderson, R. F. D.  
J. M. Richardson.....Anderson.  
M. W. Strickland.....Pelzer.  
J. W. Wideman.....Due West.  
J. D. Wilson.....Lowndesville.  
W. W. Wilson.....Williamston.

#### ANDERSON.

(ANDERSON COUNTY MEDICAL ASSOCIATION.)

*Secretary, J. B. Townsend, Anderson.*

Frank Ashmore.....Anderson.  
R. B. Day.....Pendleton.  
W. R. Dendy.....Pelzer.  
J. L. Gray.....Anderson.  
J. C. Harris.....Anderson.  
W. R. Haynie.....Belton.  
B. A. Henry.....Anderson.  
W. S. Hutcherson.....Anderson, R.F.D.  
W. H. Nardin.....Anderson.  
W. H. Nardin, Jr.....Anderson.  
R. P. Ransom.....Williamston.  
J. B. Townsend.....Anderson.  
W. W. Watkins.....Pendleton.  
R. G. Witherspoon.....Anderson.

#### AIKEN.

(AIKEN COUNTY MEDICAL SOCIETY.)

*Secretary, W. C. R. Turnbull, Aiken.*

T. G. Croft.....Aiken.  
B. S. Dunn.....Aiken.  
T. P. Edwards.....Graniteville.  
L. B. Etheridge.....Wagner.  
W. S. Eubanks.....Talatha.  
J. I. Green.....Bath.  
H. T. Hall.....Aiken.  
M. M. Lecroy.....Langley.  
W. E. Mealing.....North Augusta.  
C. F. McGahan.....Aiken.  
J. A. Millhouse.....Perry.  
V. Mott.....Aiken.  
H. J. Salley.....Salley.  
W. H. Shaw.....Langley.  
C. A. Teague.....Graniteville.  
W. C. R. Turnbull.....Aiken.  
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W. D. Wright.....Langley.  
B. F. Wyman.....Aiken.  
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L. J. Blake.....	Spartanburg.
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G. A. Bunch.....	Spartanburg.
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	Spartanburg.
	[R. F. D. No. 5.

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1872.....	J. C. Spann.....	Catchall.
1873.....	A. A. Moore.....	Camden.
1873.....	M. G. Salley.....	Pinewood.
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1874.....	J. F. Pearce.....	Claussens.
1874.....	O. B. Mayer.....	Newberry.
1875.....	T. G. Croft.....	Aiken.
1875.....	Manning Simons.....	Charleston.

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### South Carolina Medical Association.

Next Annual Meeting at Columbia, S. C.,  
April 18th, 1906.

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405 Perry Ave.,

GREENVILLE, S. C.

# THE JOURNAL

OF THE

SOUTH CAROLINA MEDICAL ASSOCIATION.

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## EDITORIAL COMMENT.

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### THE APPROACHING ANNUAL SESSION.

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On the 18th of next month the State Medical Association will hold its annual session at Columbia, the second under the new constitution. In the two years which have passed since the adoption of the present constitution the association has grown in strength and influence, and a livelier interest in medical affairs has been manifested by physicians in all sections. In nearly every county a medical society has been organized and become affiliated with the state body, and two district associations have been formed, the Pee-Dee Medical Association and the Fourth District Medical Association. Most of these societies are doing good, earnest work, and are becoming influential factors in their respective communities. With this increased growth and

activity we should have the largest and most fruitful meeting ever held.

The importance of the House of Delegates was impressed upon all who attended the Greenville session, and there is no doubt that this body should be composed of picked men. This year two changes of constitution will be considered by the delegates. One proposes to make the chairman of the Executive Committee of the State Board of Health and the chairman of the Medical Examining Board members of the House of Delegates. Both of these boards are most important parts of our working machinery and should unquestionably be represented in the legislative body. The other change refers to the Medical Examining Board. It is proposed that the term of office on this board shall be limited to two years and that the incumbent shall be ineligible for re-election. We see no objection to electing medical examiners every two years, but to limit them to a single term of service would be in our opinion a grave error. Upon these men devolves the important duty of protecting the profession and of safeguarding the public from incompetent practitioners, and such high office should not be given merely for the honor that attaches to it. Ability alone should determine the selection. It is not easy to determine an applicant's fitness to practice medicine and surgery. An examiner should possess a nicely-balanced judgment, a fine sense of discrimination and a fair mind, as well as an ability to frame his questions clearly and tersely. These qualities grow with experience, the competent examiner becoming more and more competent as the years pass. The proposed resolution would lop off the branches just as the buds begin to open.

### A GREAT BENEFACTION.

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Many years ago a citizen of Charleston, Mr. Thomas Roper, bequeathed his fortune for the building of a hospital wherein all creeds and all colors without distinction should receive medical and surgical treatment. The building first erected was partly destroyed by the earthquake and has since been closed. But



two years ago a member of the local medical society, Dr. R. S. Cathcart, conceived the idea of utilizing the accumulating fund in accordance with the purposes of the donor, and the magnificent structure recently completed is the brilliant realization of that dream. The new hospital is constructed in strict accordance with most advanced requirements, and both races receive like accommodations and like treatment. Not only the medical profession and the people of Charleston, but the profession and the people of the whole State should feel proud of the Roper Hospital—and prouder still of the broad and liberal-minded man whose generous benefaction made it possible.

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#### DRUGGISTS CLUBS.

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Not long ago we heard the suggestion made in one of our larger centers that the druggists should organize a club among themselves for the purposes of social intercourse and scientific discussion, in the manner of the local medical societies. Why not do this in every county? Such clubs every now and then could arrange a meeting with the local medical society in order that druggists and physicians might discuss together matters in which they are both interested. Such intercourse, we feel confident, would establish a better understanding between the kindred professions and in every way be mutually helpful. We heartily commend the suggestion.

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#### ORIGINAL ARTICLES.

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##### THE MODERN MASTOID OPERATION\*

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E. W. CARPENTER, M. D.  
GREENVILLE, S. C.

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Every specialist who has a hobby is often a dangerous man and one on whom the conservative physician must hold the

lines. But a greater menace to a community are those physicians who prescribe sweet oil and laudanum for earache, and later with all honesty, tell parents the child will outgrow its P. O. M. If they said it will probably outgrow the child, they would have better reasons for their air of wisdom. As a life saving measure, few operations equal and probably none surpasses the modern mastoid. Recent progress in the surgery of this region has been brilliant and the aurist has, by a ceaseless, conscientious application, kept in the foreground of his science.

It is only in late years that the prevalence of mastoid disease has forced on the public and general practitioner an interest in a degree commensurate with its importance. Now the aurist is early sought, instead of waiting until the stress of imperative necessity demands him.

It is not long ago that general surgeons laughed at specialists as pretenders when the employment of the knife was necessary, and there was some justice in their attitude.

It spurred the hesitating aurist to the necessity of more accurate anatomical and technical knowledge and to-day eminently satisfactory methods have replaced the inadequate ones of a few years back.

Another factor which has contributed to our present state of perfection is the education of the public to the benefits of specialism. People who used to seek "another doctor" when the use of the knife was suggested, now readily acquiesce and accept institutional attention, which means much in contributing to the final result.

In the light of the history of this operation we must acknowledge our indebtedness to our ancient predecessors for much sound wisdom and medical learning. Some of their methods differed but little from ours of to-day, i. e., in the 5th century B. C., Hippocrates advised for A. O. M. "local blood letting and the instillation of warm mild drops into the ear, the application of steam, a cathartic and absolute rest." For C. O. M. P. he recommended "warm irrigation, followed by the use of astringent drops, especially

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\*Read before the Tri-State Medical Association, Feb. 28, 1906.

the acetate of iron." These remedies differ in no material respect from our present day treatment. He also advised "the removal of aural polypi."

The first period in the history of the mastoid marks the era when surgical measures were used from a casual knowledge and can be called the experimental stage. "This was previous to 1864." The modern operation dates from then until the present.

"In 1656, Rolfinck first suggested the artificial opening of the mastoid. In 1677 Riolan advised a similar procedure for cure of deafness and tinitus. Valsalva, in 1740, utilized the spontaneous opening of the mastoid as an agency for the cure of otorrhoea by syringing through the fistula into the tympanum."

"The priority for *making* the first artificial opening in the mastoid, belongs to the French surgeon, Jean Louis Petit, 1674."

The operation suffered many vicissitudes, "until 1791, when the Danish Court physician, J. J. VonBerger, was operated on by Kolpin for the relief of tinitus. The operation was a failure and on the thirteenth day after it, Von Berger died of purulent meningitis and sinus thrombosis."

Again in "1824, we find Webber operating without success," this date marks the end of the period in which the operation was practiced empirically and inaugurates the era in which we are proud to share. But we can never pay the debt which we owe to that countless number of silent workers all along the line, who have relieved their thousands and helped to perfect this branch of medicine until it stands a glorious monument, erected in the 19th century.

"To the labors of Jean Gaspard Itard, 1773-1858, belong the credit of placing treatment of ear diseases in the specialties."

It is noteworthy that during the infancy and development of the operation we find no English contributors of note, except Sims in 1787 and Sanders in 1808, but since the middle of the last century, we find Toynbee and Wilde, whose "Inci-

sion" became famous, and is even now practiced, though its benefit is limited to those cases of periostitis in children, it demands, as a general measure, the serious consideration of many specialists.

The first American surgeons to revive the opening of the mastoid cortex for suppuration, were Trumbull and Crosby, 1864. The latter using no other instrument as a perforator than an ordinary gimlet.

In 1885 the Schwartze operation had entirely superseded the crude technique of the earlier operators, and yet this operation depending on the use of chisels, gouges and curettes, must have been crude when compared with the modern technique of this century.

The advent of the Ronguer has facilitated more than any other invention, the ease, safety and perfection of the present method over the description of the original, by Schwartze.

Before the adoption of this method New York furnished some prominent men who relied on the trephine and after working it in a direction inward, upward and forward, to a depth of 22 centimeters, abandoned the trephine and resorted to probe or small curette, and if at this depth they failed to find pus or the antrum, the operation was abandoned with the hope that the pus would find an escape externally.

I have no means of knowing how many of these cases where the antrum was undiscovered ended fatally or whether their last condition was worse than the first, but I do know that no progressive aurist of to-day would consider such an operation complete until he was satisfied the antrum did not exist, whether from proliferative, ostietis, or congenital absence.

Dr. Gruening of New York was the first to advise and practice the "complete removal of the mastoid tip in all cases where the suppuration had extended beyond the antrum and involved the body of the bone."

In regard to modern technique, there is no use for me to dwell at length on the different steps. I insist though, on the skin incision being sufficiently long, with



a posterior arm, the flaps carefully retracted with the periosteum attached, which is readily done by the use of Langenbeck's elevator. This is fashioned like a hoe with a sharp edge, (it is an ideal instrument).

The whole working field should thus be first exposed and if conditions demand it, a continuation of the primary incisions will always be sufficient to expose diseased areas, no matter how extensive, or in what direction they extend. These ample flaps heal speedily, leaving less deformity than the single incision with its deep sulcus, over which there is generally a more marked depression and more frequent demand for grafting during the lengthier healing process.

To Gruening's practice of completely removing the tip, I would add Whitting's dictum that "Invariably the cells at the posterior root of the zygoma should be thoroughly eradicated in those cases where pus has extended beyond the antrum." For many a post operative temperature has dragged slowly along and healing been delayed, while pus was being disposed of in this region.

Before attempting to penetrate the cortex, the surgeon should be able to interpret the location in a general way, of the sinus and antrum, by the size of the mastoid process, whether it be large or small, long, flat, broad, short or narrow, here is where the extensive flaps and thorough exposure serve their purpose.

In the further technique, I would say that mature judgment, and the highest surgical and anatomical knowledge, in some cases will not prevent an accident to the sinus, but except in unusual conditions, wounding of the facial nerve of the external semi-circular canal, is unardonable.

I believe the safest way to attack the process is with a gouge. Making the initial incision at the sup. ant. corner of the supra-meatal triangle, extending it down to the tip, including only the cortex, then the diploea can be removed with the gouge and the underlying structures investigated and removed, until we have a definite knowledge of the location of the

sinus. At this stage of the operation, the tip having cleaned out, one can proceed upward, thus attacking the antrum at leisure, with much more space to work in and all the land marks in view. A mistake often made, is to attempt immediate entrance of the antrum through a narrow and deep channel which can not be inspected thoroughly.

While the antrum is always found within the boundaries of the supra-meatal triangle, their dimensions do not often coincide. So it is unscientific to expect always to enter that cavity through a deep narrow hole, whose location has been placed by numerous inadequate rules. It is wise to exercise caution rather than by restlessness invite evil consequences.

Dr. Knapp once exhibited a bone where the sinus was directly over the antrum.

Whitting says, "In over 800 mastoids, he has never found it absent or obliterated, though a few such cases have been reported."

When there is difficulty in locating the antrum, those of us who are not artists, are permitted to insinuate between the membranas and bony walls of the meatus, a probe carried to the inner wall of the tympanum, thus determining the limit of depth at which we can proceed, this also establishes the angle of the meatus. This probe may be bent so as to enter the antrum through the aditus and held in position until its point is discovered. This measure is undesirable in acute conditions because it generally makes hearing worse by interfering with the ossicular chain.

Once entrance has been gained into the antrum, we can then proceed to eradicate the zygomatic cells and return to the antrum, removing all softened structures and overhanging walls, making it as shallow and smooth a cavity as possible.

These remarks apply only to those cases where the mastoid is developed. In the infant there exists only one accessory cavity, viz., the antrum, there being no mastoid process before two years of age, all the indications for drainage are met, when the antrum is thoroughly opened. Just here, permit me to draw your atten-

tion to the location of the antrum in these young patients. Its base line will generally be found on a level with the roof of the tympanum. The temporal ridge and Henle's spine are absent in the majority of cases under three years of age. Rarely any instrument except a gouge is needed to penetrate the soft cortex.

In making the initial skin incision, in infants, it is well to bear in mind the fact that the facial nerve emerges just posterior to the middle of the meatus, instead of through the under surface of the petrous portion of the bone, so the incision should be carried to the bone only in its upper end and the periosteum should be peeled off the lower portion with great care, lest we cause a facial paralysis!

Let me here emphasize the advantages of the complete over the conservative operation, which is still defended by numerous operators.

First, it is dangerous to work in a narrow opening with a contracted orifice.

Second, it is unscientific.

Third, it is impossible by the eye to arbitrarily separate healthy from diseased bone.

Fourth, risk of nature's refusing to accommodate us in absorbing dead tissue which is invariably left in situ.

Fifth, added distress to a patient, consequent to a prolonged healing and the necessity for recurrence to secondary operation, which view from our standpoint, or from the patient's, is not desirable.

Without entering into a detailed description of the technique of the operation and the complicating conditions that may arise, or mentioning the subject of dressings or after treatment, I will attempt a brief review of the indications for the operation. These are influenced by one's attitude towards radicalism or conservatism, some men insisting on exploration if pain has lasted only twenty-four hours, while at the other extreme, there are those who do not think it necessary to open the mastoid until inflammatory edema and fluctuation expose the blun-

dering of extreme conservatism. So to define an exact symptomatology, would appear bold.

However, there is a course which can be pursued with much definiteness, when all the indications are considered in the light of our knowledge of recent pathological findings.

I do not deny that there are some cases, especially those with marked constitutional disturbances and indefinite local symptoms that tax the most astute diagnosticians. As an illustration, permit me to cite the following case reported by Dr. A. B. Duels.

"Mrs. B. on the last of January, 1904, developed a case of grippe, with acute catarrhal symptoms in the naso-pharynx and a slight bronchial irritation. On Feb. 2nd, owing to acute pain in both ears, I saw her in consultation. Both drums were bulging. The right mastoid was exquisitely tender on pressure over antrum and tip. Under chloroform anesthesia, both drums were freely incised. Smears taken from the ears, directly after incision, showed presence of streptococci, and a diplococcus resembling the pneumococcus, in both. The temperature which was 101° F., dropped to normal in a few hours. The mastoid tenderness had entirely disappeared within 24 hours. I did not see her again for 48 hours, being assured there was no pain in the mastoid. A "slight feeling of chilliness" had been experienced when the temperature rose to 102.4° F. (see chart). During the interval between that and the second slight chill, there had been two vacillations in temperature, of about two degrees. Examination of the ear showed both to be discharging freely; there was no pain; no tenderness on pressure over the mastoid region. A slight bronchial cough was present. In eight hours from this time the temperature had dropped to sub-normal with profuse perspiration and, a few hours later, with a severe chill, lasting one half hour, rose to 105.8° F. No physical signs over the mastoid, or sinus, or along the course of the jugular, showed any evidence of thrombosis. The respiration was 32 per minute, the pulse



116 per minute. The attending physician was unable to find any signs in the lungs except an occasional rale in the large bronchi.

Dr. Janeway and Dr. McKernon were called in consultation. We were all agreed that the diagnosis lay between a developing pneumonia and thrombosis of the lateral sinus, or jugular bulb, and that, in the absence of any physical signs of the latter, it was wiser to wait further developments. A blood count made at this time, showed a leucocytosis of 42,000. In six hours the temperature dropped to 103.5° F., and then, with a slight chill, rose again to 105° F. The respiration at this time had gone down to 22 per minute; the pulse to 100 per minute. Frequent cough was present, and by the next morning, when Dr. Janeway saw the case with Dr. Kimball and myself again, the sputum was "so typically pneumonic" (blood stained) that it was considered sufficient confirmation of the diagnosis of pneumonia, although no further physical signs in the lungs were found. Twenty-four hours after the severe chill a drop in temperature to 99° F., with profuse perspiration occurred. The pulse went down to 80 per minute; the respiration to 20 per minute. The ears were discharging freely, and, no mastoid tenderness being present, I did not see the patient again for some days, a diagnosis of pneumonia having been made. Four hours after the last drop in temperature to 99° F. a chill occurred with a rise in temperature to 106° F. In eight hours it dropped again to normal with a profuse sweat and never rose again above 100; the patient making an uneventful recovery without cough or expectoration. At the end of a month I saw the patient. Both drums were healed; the hearing was acute; there was no tinitus."

Here a distinct chill marked each rise of temperature; a profuse sweat occurred with each drop. Except for the local physical signs, the whole aspect of the case was one of sinus thrombosis. Yet a diagnosis of pneumonia was made on the presence of blood stained sputum, although auscultation signs were as little

characteristic of pneumonia as were the local signs of intracranial extension.

1st. In estimating the value of individual symptoms and mentioning them in order of importance, I would begin with mastoid tenderness, laying stress on the four points to be investigated, viz., antrum, tip, area over emergence of mastoid emissary vein, premastoid lamina, pressure being made downward and backward in the meatus. In eliciting this symptom, a skilled finger has every advantage. Under its searching touch a patient often cries out in intense pain, who refused to admit it under the uneducated enquiry. The secret is, that sufficient pressure must be made on the cortex to so indent it that the nerves in the muco-periosteum of the cells are compressed.

2nd. Then fundus changes, sagging of sup. post. wall, or bulging of the membrane.

3rd. Pain. In children this is often indefinite, but always causes restless sleep.

4th. Microscopic findings, streptococcus pure or pneumococcus, should put us on the *qui vive*.

5th. Sudden cessation of discharge should make us anxious and watchful.

6th. Temperature is unreliable.

7th. Disturbance of function is unsatisfactory.

8th. Enlargement of glands below the mastoid and behind the sterno-mastoid muscle. These glands drain the mucous-membrane and bone of the mastoid region.

Thus we find that single symptoms do not furnish us ground for positiveness, but when the careful observer weighs the history, physical signs and systemic manifestations, there is seldom wanting any evidence.

In conclusion, let me say, when a specialist has decided that an antrum contains pus and does not so inform the patient or his friends and advise a mastoid operation, he has not kept faith with his trust.

I hope I will not be considered extreme, when I say our duty is to advise opening the antrum in every case of P. O. M.,

by this measure we establish ideal drainage which in many cases is not accomplished by incision of the drum, for we would have fewer number of cases of bone involvement if the purpose of our interference was accomplished.

The operation of anthrectomy is not dangerous and many lives are lost by our delay and timidity in advocating what we must confess to be the best and only sure remedy.

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## A RETROSPECT

### Of Fifty Years' Progress in Medicine.

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BY M. J. D. DANTZLER, M. D.,

ELLOREE, S. C.

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(Read before the Orangeburg Medical Society,  
February 19th, A. D. 1906.)

Having been in active practice for forty-five years, and a medical student forty-nine years, I may be pardoned by this society for presuming to glance back and indulge in a retrospective view of the science and practice of medicine, surgery and gynecology as compared with the same of to-day.

Fifty years ago doctors did not know why, in some cases of nausea and vomiting in pregnancy, "chicken gizzard tea" would give relief; but some old women believed in it notwithstanding the amusement of the doctors; but afterwards some one discovered ingluvin in the mucous membrane of the gizzard, and ingluvin was prescribed for nearly every case of nausea and vomiting with varied results. Among many remedies for intermittent fever pills of spider web were recommended; but we did not know why. Afterwards it was said to contain arsenic. The profession had practically abandoned the use of the crude peruvian, oak, poplar and cherry barks, boneset and dogwood, and were using Powers and Wightman's sulphate of quinine. Decoctions of poppy heads ceased to be used and that then the great and wonderful remedy, morphine, had to be given very cautiously, especially when there was high

fever, as it would do irreparable injury to the brain under such circumstance, and the doctor, in many cases dared not tell the patient that he was giving morphine, for it was considered by the laity a very dangerous remedy. Quinine was given only in doses of one to two grains every two hours until a German author recommended doses of ten, twenty, thirty and even forty grains at longer intervals.

Fifty years ago the country doctor had no means of measuring the degree of fever, and depended upon the number of heart pulsations in the minute, the heat of the skin and other uncertain signs. Take for instance influenza, as grippe was called then, when the patient is alternately hot and chilly, with cold extremities and a pulse of 70 to the minute. It was difficult to decide whether the patient had fever or not: now the fever thermometer often reveals in such cases a temperature of 103° or more. Up to 50 years ago blood-letting was the first remedy in pneumonia and all inflammatory diseases, as also in high malarial fevers, for the maxim was "*ubi irritatio ibi fluxus*," and venesection headed the list of remedies and calomel and antimony came next in order for all inflammatory diseases and all high fevers with a "full and bounding pulse."

In pneumonia, after venesection, tartrate of antimony and potash with calomel were administered in doses of one and two grains repeatedly and recommended by the old authors to be pushed to tolerance. The death rate under this treatment was fearful, tolerance often attained only in the death of the patient. Finally some discarded antimony altogether fearing it as a deadly poison; while others obtained more favorable results by using it in doses of 1/16 to 1/8 grain.

Along in the fifties of last century Dr. Norwood was experimenting with *veratrum viride*, and there was much discussion in the profession, pro and con, about it as a remedy in pneumonia. It was experimented with by some of the profession for several years with varied results and some fatalities. The trouble



was that it required constant and close watching of the pulse—we had no thermometers then—and this could not be safely left to the ordinary untrained nurse. After a few years it was entirely abandoned by the physicians of Orangeburg County, so far as I know.

Therapy in pneumonia gradually underwent a radical change, and it was found that mild expectorants such as ipecac, squills and other synergistics, in combination with ammonium carbonate or ammonium chloride, gave better results, especially when the heart was toned up by digitalis or strychnine. In the treatment of all lung troubles the old medical writers were accustomed to quote from Latin authors the favorite maxim, "In omnibus morbis pectoris ad vias urinales spectandum"; and diuretics were freely given to act upon the kidneys and thus clear the system from "morbific humors."

Typhoid and other fevers were treated with calomel, neutral mixture, sweet spts. nitre, ammonium carbonates and acetate, cream of tartar and opium. For tympanites turpentine was recommended to be given in teaspoon to tablespoonful doses. Perhaps 40% died under this treatment with dark, dry fissured tongues, the lips and teeth covered with dark sordes. Quinine was seldom given at all in typhoid fever. When a pregnant woman was the victim of remittent fever she *must* not take quinine for fear of abortion or miscarriage.

When calomel was prescribed cold water was absolutely forbidden and the patient was drenched *ad nauseam* with warm teas, when nature indicated cold water as the proper drink. Salivation was much more common then than now. I have seen infants with cholera infantum, a few hours before death, with their little hands outstretched towards the water pail pleadingly for nature's refreshing remedy to cool their thirsty, parched tongues, and it was denied them and the detested warm tea substituted. I have known the offensive putrid discharges from the sloughing glands of the bowels to be locked up in the intestines by the administration of opium, kino, catechu,

acetas plumbi and other astringents until offended nature revolted and threw off the putrid debris with most fearful and too often fatal results. Of course under such treatment death resulted in a great many cases.

Even in the fifties and sixties of last century any and all cases of convulsions, except epilepsy, caused terror and fearful forebodings in the minds of the family and of the physician as well. For convulsions, and especially puerperal convulsions, venesection was *the* remedy. I well remember the first case of puerperal convulsions I unexpectedly came across in the case of a negro woman when I was a young M. D. The first remedy suggested to my mind was, as the books recommended, "venesection." As the convulsions were almost continuous and I had no assistance save an old woman, I jumped astraddle of the patient, placing my knees in the palms of her hands to keep her still, and, in my haste, fumbled to place the point of the lancet on the proper vein in the shaky, jerking arm, until I finally struck the vein: under the circumstances the patient did not bleed enough to suit me. So I gave potassium bromide, a new remedy at that time, with valerianate of ammonia, etc., and was somewhat surprised that she did not die as most of such cases were then expected to do. Now we are scarcely alarmed at puerperal convulsions; for we easily manage it with chloroform inhalation, followed by choral hydrate and bromide of potash, and morphine hypodermically. Venesection is never necessary and I do not think we need bother with *veratrum viride* either.

It was in the sixties of last century if I remember rightly; for I am writing this paper entirely from memory, having not consulted any records or books for the purpose, and if I commit an error it will be of the memory and not intentionally. It has been said that the first faculty of the intellect or mind to fail, on account of old age, is the memory.

It was in the sixties that Lister surprised the world with the theory of antiseptis and formulated listerine, which, in

connection with bacterial discoveries and other later antiseptics, wrought hitherto unthought-of wonders and completely revolutionized the practice of medicine, surgery, obstetrics and gynecology.

A good many years before this it was discovered that chloroform inhalation produced general anesthesia; and that general anesthesia could be prolonged for the completion of long and tedious surgical operations with little or no danger to the patient. This discovery, viewed from a surgical stand point, was one of the greatest God-given boons to suffering humanity and to the surgeon as well. Previous to the use of chloroform it required the very highest kind of courage and nerve to amputate a limb. I remember, when a boy, one of our slaves left alone in the cabin and attacked with epilepsy, ran one of her feet under some red-hot logs in the chimney and burnt her foot to a char. Dr. Dwight, then a resident of the village of Orangeburg, amputated the leg—of course without anesthesia—and I shall never forget the agonizing cry, shrieks and struggles of the patient, mingled with the scoldings and mild profanity of the surgeon. As bacteria had not yet been even dreamed of there was profuse suppuration in the stump and strappings and dressings had to be renewed daily: healing by first intention was almost impossible. Now, under chloroform or ether the patient feels no pain and the surgeon is neither hurried nor embarrassed by the shrieks and struggles of his patient. Antisepsis thoroughly carried out leaves no danger of bacterial infection and healing by first intention is assured with no suppuration to drain the vital forces of the system. Since the use of general anesthesia there is scarcely an organ in the body which the surgeon's knife does not reach. I forget who laid claim to the first to discover anesthesia by chloroform inhalation; but the late Dr. Wilhite of Anderson, S. C., insisted that he was ahead in the discovery. Since Dr. Wilhite's death I have read somewhere that he permitted a patient to inhale chloroform, for what purpose I do not know, and after inhalation for some-

time he found that he could not arouse the patient and so concluded that death had about resulted from the experiment. Seized with sudden fear of prosecution for manslaughter he ordered his horse saddled to flee into Georgia: but just before he started he was informed that the patient was reviving, and so postponed his flight indefinitely.

Fifty years ago the fever thermometer had not yet been invented. I have no recollection of seeing one while surgeon of the Confederate States Army. I am pretty sure that it was not in use then. The first impressive recollection I have of using it was in 1870 when I put it in the mouth of a fat old lady whom I found tossing from side to side and beating the bed with her hands under a fever of 105 degrees of temperature. She did not know what it was and took it for a new remedy. She became perfectly calm while holding it under the tongue, probably trying to think how it imparted its curative properties to her fevered system. When I removed it she remarked, "That is a great remedy, Doctor. I feel better already." She lived to the good old age of 84 years, never having such a high fever again, and is buried in this town. How could we get along without the thermometer now?

Forty or fifty years ago nausea and vomiting in bilious remittent fever was a thing to be dreaded. Doctors gave emetics to *evacuate* the stomach—put emplastrum cantharidis *on* the stomach—wrapped poultices *about* the stomach—and generally stirred *up* the stomach with but seldom any benefit until he *wore out* the stomach with one or two days' vomiting. I had enough of such cases when assistant surgeon at Alum Bluff on the Apalachicola River in Florida, in the fall of 1863. But after the Confederate War the hypodermic syringe was invented—and what a blessing to suffering human mortals! Some made a vigorous fight against its use as criminal inhumanity. Now, by means of the hypodermic, we can relieve vomiting in thirty minutes, and that without placing a nauseating drug inside the stomach where the thick



catarrhal mucous coat on the mucous membrane, in the gastric catarrh of remittent fever, prevents it from being absorbed.

Probably a little over fifty years ago women who unfortunately suffered with laceration of the cervix uteri, of the vagina or peritoneum or cervico-vesical fistula had to drag out a miserable existence to the end of their lives. About this time Dr. J. Marion Sims, a native of South Carolina who had removed to Alabama became very intensely interested in the sufferings of these unfortunate females, and commencing with an ordinary tablespoon as a dilator of the vagina in Sims' position and the knee-chest position, he several times stitched a vesico-vaginal fistula in the same patient with silk ligature without successful results. Walking along the street one day in deep thought as to what kind of a ligature would be best, his eyes fell on a piece of silver wire which had been taken from a piano. Instantly the idea flashed into his mind that that was the kind of ligature he wanted. With this silver wire he operated again with success. Abandoning the spoon he invented Sims's speculum and also invented several other gynecological instruments, by the aid of which he made world-wide reputation by his successful operations in New York and Paris; and thus he became the father and founder of the science of gynecology.

Up to about the year 1880 I used to think that too little attention was paid to therapeutics. Medical writers and lecturers seemed to pay most of their attention to pathology and description of the symptoms of diseases. We have now few such symptom-descriptive writers as Watson of London and Samuel Dickson of Charleston, S. C. In their beautiful classical English diction they enthused the reader and the audience to an intense interest in their descriptive pictures of the symptoms of diseases. But somewhere about 1880 there began a vigorous search for new remedies, and pharmacists vie with each other in adding new material to the *materia medica*, and chemists, in discovering new therapeutical

agents, both by analysis and synthesis, and remedies have been greatly multiplied. It remains for the medical profession to sift out and settle down on the most innocent and the most useful of these new remedies.

In the seventies when I lived near the mill ponds I sometimes lay in bed with chill and fever and listened to the surging, waving and tumbling notes of queer music produced in my system by quinine, and the thought would suggest itself: Can this be the death screams of billions of living micro-organisms in their death struggle with quinine? I am glad to have lived to the present when it has been proven beyond a doubt that malarial fevers are caused by living ameboid hematozoa in the blood, and that as a host the mosquito, *Anopheles claviger* conveys the entozoon from one patient to another. But I do not believe, as some of the medical profession do, that the mosquito is the only and original source of the malarial hematozoon any more than I believe that the house fly is the only and original source of the *Bacillus typhosus*: but I believe that the malarial entozoon is conveyed to and from the patient in the mosquito's body, and that the *Bacillus typhosus* is carried to and from the patient on the feet and tongue of the housefly.

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#### AN INTERESTING CASE OF CONTRACTED PELVIS RELIEVED BY CAESARIAN SECTION\*

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C. B. EARLE, M. D.,  
GREENVILLE, S. C.

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The case that I have to report to you to-day is interesting not because of any original operation that I have to report nor because of novel or unusual methods of treatment, but because of the unusual size of the patient and the comparative ease with which she carried the child almost to full term and the freedom from

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\*Read before the Tri-State Medical Association, Whitestone Lithia Springs, S. C., Feb. 27 and 28, '06.

complications during convalescence and her complete restoration to health.

I was called to see Mrs. B. on the 2nd of last November by Dr. T. T. Earle to whom I am indebted for the case. She was suffering with severe abdominal pains and was having strong uterine contractions, the cervix was slightly dilated and there was some little hemorrhage from the uterus. She was moved to the Greenville Sanitarium where she was put to bed and kept until the subsidence of the uterine pains. She remained under my care until four weeks after the birth of her child.

*Family History.*—Both parents are living and are in good health. Both are 5ft. 5½ inches tall and are stoutly built.

Grandparents were of average size.

Has four brothers and five sisters, all about the average size and all are in good health. Had one sister to die in infancy of whooping cough. Mother miscarried twice. Labors otherwise normal.

*Personal History.*—Was twenty-three years old, was small at birth but does not now know weight. At fifth week weighed five pounds and at eighteen months was smaller than an infant brother recently born. She had diseases of childhood, none serious. Had typhoid fever in 1892, when she was sick for several months. In 1903 had pneumonia and was six weeks in recovering. At one time was employed as a school teacher but for the last few years has been with different theatrical companies. Since last April has been with a street carnival company. She was married last April. She has always menstruated regularly since puberty. Last day of last menstrual period was April 30th. Quickening was first noticed August 24th.

*Physical Examination.*—Height thirty-four inches; weight thirty-nine pounds; blonde; all faculties normal; intelligence above average; erect; upper parts small but well formed, lower part very small, out of proportion to upper. Heart and lungs normal; kidneys normal.

As foetus developed increase was from side to side and forwards. At the time of her operation the fundus of the uterus

was at a lower level than it was four weeks before. The lower ribs were flared out widely to give room for the enlarging uterus.

*Measurements.*—External conjugate or diameter of Baudelocque was 5½ in. Distance between iliac spines, 8½ inches; distance between crests 8¾ inches; distance between trochanters, 9¼ inches; oblique conjugate, 2¾ inches; distance between tuberosities of ischium, 2 inches. Child was lying with head to right, back to front. Waist measured at most prominent part thirty-four inches; from symphysis to ensiform cartilage distance was thirteen inches.

Operation was done January 16th with incision through linea alba. The uterus was opened by vertical incision through anterior surface, membranes ruptured and child delivered, assistant compressing the uterine arteries all the time, cord was cut and placenta with membranes removed. Cervix was dilated. Uterine incision was closed with catgut sutures, abdominal wound with interrupted silk worm gut.

Stitches were removed on the 8th day; union by first intention. There was an easy convalescence without complications excepting that from the fourth to the ninth day there was an afternoon rise of temperature from one to two degrees; highest was on the fifth day when it reached 100 3/5 degrees. There was no ascertainable infection. Morning temperature was normal. Pulse steadily fell from 120 to 90 on the ninth day.

Child weighed at birth 4½ pounds. At four weeks weighed 5½ pounds. For first ten days there was no milk in mother's breast, but since there has been a gradual increase until when she left the child was getting at least a fourth of its nourishment from her mother. Patient left on the 29th day for her home in Nebraska, carrying her child with her; both in good health.

My reason for doing a Sangér operation instead of a Porro was on account of the wishes of the patient, who insisted, notwithstanding the dangers at the time of operation and afterwards were ex-



plained to her, that the uterus be left if possible. I think the better operation would have been to have removed the uterus and so have prevented future pregnancies, and also to have avoided the increased danger of post-partum hemorrhage and the greater danger of infection by reason of the uterus remaining.

The father of the child is also an interesting man. He is forty-two inches tall. His body is well formed above the waist and very muscular, below the waist is small. His parents are also living and in good health. Both are of average size.

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### VERATRUM VIRIDE.

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L. B. BATES, M. D.,

S T. MATTHEWS, S. C.

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It is a very difficult task to ascertain the true status of a drug that has been so highly lauded on the one hand, and so strenuously condemned on the other, as has been the case with veratrum. Perhaps there is no article of the *materia medica* that has been the victim of more misconception as to its physiological action, therapeutic application and efficacy. It has never lacked over enthusiastic advocates, nor merciless and unwise decriers. It is with the hope of correcting in some small degree these misconceptions of the true nature of the drug, and overcoming to some extent the groundless prejudice to its more general use, arising from a perverse and persistent fear of it, from its power over the cardiac and arterial system, that I venture the preparation of this paper.

*Veratrum viride* was known and used by the Indians and the pioneers. It was used as a medicine as early as 1811. *Veratrum* is the chief one of five American species of the tribe *Veratrea* order *Melanthacea*, a genus of lilaceous plants. The root alone is used medicinally. Being a perennial, the roots should be gathered in the autumn of the second or third year. The efficiency of the drug depends on

this, and also on the proper drying and marketing of the product. Very much of the disappointment and the skepticism in reference to the use of veratrum is due to negligence in carrying out the conditions necessary to produce an article possessing and conserving the active and essential principles of the drug. Fortunately, an eminently reliable one is ever available in the Norwood's Tincture prepared by the Shakers of Mount Lebanon, N. Y. The U. S. D. tincture is 10% weaker and is almost entirely responsible for the failures to secure desired results of all those who have been disappointed with and have condemned veratrum. "A reliable physiologically tested remedy may make a reputation and an inert one may destroy it."

Though some prominent New England physicians had used veratrum in the early part of the past century, and considerable attention was directed to it by Dr. Osgood's essay in 1835, they failed to grasp its power as a cardiac or arterial controller, and it was not generally prescribed until the emphatic proclamation of its virtues was made to the public by Dr. W. C. Norwood, of Cokesbury, S. C., in 1850. Norwood was the first to discover, demonstrate and publish to the world the fact that veratrum would control the vascular excitement in febrile and in inflammatory conditions, and control the pulse and reduce the temperature. A discovery—a contribution to the healing art within entitles him to rank with that other eminent South Carolinian, J. Marion Sims, as one of the world's great benefactors. Your essayist deems it one of the greatest privileges of his life to have seen this great physician, Dr. Norwood, and to have heard him lecture on the great merits and marvellous achievements of his *veratrum viride*. It was also as great a privilege to see the venerable Eli Geddings rise, trembling with the infirmities of age, and reply to him, and accuse him in a humorous way "of an overweening fondness for his bantling." This was in 1869 and time has effaced the most that Dr. Norwood said but I remember that he said veratrum, alone, would control and relieve all febrile and

inflammatory conditions with the single exception of bilious pneumonia, which would require calomel in conjunction.

The medicinal virtues of the drug are due to its two alkaloids, jervia and veratroida, and a resinoid substance.

Let us now note very carefully its physiological action. Knowing that well we will possess the key to its successful therapeutical use: In experiments on animals, in full doses, the contents of the stomach are first evacuated, then of the gall bladder, *no catharsis*, prompt emesis without severe depression. It lowers in a remarkable manner the frequency of the pulse, and, if administered carefully, this is attained without nausea. The symptoms of poisoning in animals were sluggishness, muscular weakness, trembling, and final prostration, no purging, but always profuse salivation. Sensation is affected only very late and consciousness almost not at all. There is a marked reduction of spinal reflex. Dr. DaCosta found, in experiments on animals, that abdominal veins were unusually full and explained that the relief of the vascular tension was accomplished by bleeding the patient into his abdominal veins where there was the most elasticity and the least muscular pressure on the veins.

Many physicians have been prevented from giving veratrum by an intense fear of causing death by depressing the heart. How absurd the following facts attest. Dr. Norwood says a doctor, by mistake, swallowed an ounce of the tincture without fatal results. There was extreme nausea, vomiting, some dyspnoea. The bowels were not disturbed. The sedative action on the heart was promptly relieved by alcohol. The only authentic death from veratrum was a child of 18 months who took thirty-five drops. The child became unconscious, very pale and cold, breathed stertously and had cold sweats. The pulse rate was 40, death in 13 hours. We note its wonderful powers to affect the motor centers, rapidity of absorption, marked reduction of the frequency of the heart beats and the lowering of blood pressure. The general muscular lassitude, coolness and moisture of

surface. The physiological train is very similar to blood letting.

Veratrum acts both directly upon the muscle of the heart or its local ganglia through the general vasomotor system. It is astonishing that while both Drs. Tully and Osgood recorded its power to rapidly reduce the pulse, they singularly failed to realize that it was the greatest agent in the world to relieve and control vascular tension. Dr. Tully attributed its effects to its supposed narcotic powers by a singular fatuity. Norwood proved its non-possession of narcotic powers by demonstrating that  $\frac{1}{4}$  gr. morphine would antidote its effects. Dr. Branch says that when used as it ought to be, it reduces the frequency but never the strength of the pulse, and this accords exactly with my own experience. This fact of its not impairing the strength of the pulse, if more generally appreciated, would obviate the unfounded prejudice of many to its general use. It has a very marked diaphoretic action. It also acts well on the mucus surfaces, promoting secretion, and also on the glandular system. Some text books credit it with sialogogue, chologogue and diuretic qualities. Dr. Norwood says, "Veratrum may be called the controller or regulator of the vital powers, or actions of the vascular system."

Arterial sedative, as applied to veratrum, is entirely wrong and misleading, as that name is intended to indicate that it diminishes the strength of the action of the heart and arteries, that it renders the pulsations weak and infrequent and feeble. This it only does when it nauseates and is a result of the nausea alone. Its proper and primary effect is to render the pulse slow, full and distinct and stronger, and gives to veratrum its marked importance in the treatment of that large and important class of disease belonging to the asthenic diatheses, and in which venesection is contraindicated.

Dr. Norwood also says, "You may give veratrum viride indefinitely and keep the pulse reduced down to seventy, sixty, fifty, or even as low as forty beats. All this time, for days it will be full and distinct, the skin will be cool, or cool and moist, and more or less pale, and the pa-



tient will be quiet and comfortable with a mitigation if not relief of nearly every symptom of disease. But add just enough of *veratrum viride* to nauseate and vomit freely, one or both, and you almost instantly induce every symptom or effect called the result of ultimate narcosis.

Time does not permit a mention of all the diseases amenable to *veratrum* and we notice next Dr. Norwood's use of it in typhoid fever. He says, "We rely on it as the remedy in typhoid fever and administer it with every assurance of success; put the patient on a free use of it at once and press it until every symptom is controlled or arrested. Our plan is to reduce the pulse between 55 and 75 beats and keep it at the desired point night and day. In severe cases it should be reduced at least to natural standard, or below it. By this kind of reduction the febrile and inflammatory symptoms are arrested or vanish and the patient is kept quiet and tranquil and comfortable. A great many fail of success by not reducing the pulse sufficiently or by suspending the use of the remedy before the disease is fully routed out. It is out of the question, more, it is utterly impossible for febrile and inflammatory action to exist and continue their ravages to any extent and for any great length of time when the pulse is kept at 60 or 65 beats or even less. We have kept it for days at from 42 to 45 and 50 with success. In typhoid fever, if we should meet with a case in which the fur on the tongue was yellow, and bitterish taste in the mouth, we should press the remedy to vomiting. Dr. Norwood says as to dosage: "If you wish immediate effects to an adult you would give from 5 to 10 drops every 15 to 20 minutes. In some cases of mania and convulsions from 10 to 30 drops repeated. In tetanus use 3. i Again, you can begin with 3 or 4 drop doses every 3 or 4 hours, increasing the dose one drop every portion. When the pulse is sufficiently reduced, give from 1 to 3 drops less, or you can begin with 2 drops and repeat every hour, and after controlling the circulation extend the period to 2 hours.

Now, we propose to give a few re-

marks as to our own personal experience with this remedy. I have used *veratrum* only to a very limited extent in typhoid fever, not from a doubt of its efficiency but from the fact of the nurses neglect to obey discretionary directions, necessitating extra visits to allay alarming symptoms. I have been called out of bed at night and have had to ride ten miles just to quiet the fears of patients who had neglected my most careful directions. For this reason, I fell into the habit of giving Fleming's tr. aconite, and f. e. gelsemium instead with success, and the elimination of those extra visits. In intermittent and remittent fevers in combination with minute doses of morphine and spts. nitre, *veratrum* has acted very efficiently, reducing the pulse, relieving nervous erethism and muscular spasms, producing free diaphoresis, promoting glandular secretions, and expediting convalescence. I have found it very satisfactory in the first stage of pneumonia, but have rarely had a case to treat of late years. In influenza, bronchitis, in both children and adults, I have often used it in the same combination with great satisfaction. The small proportions of morphine and spts. of nitre obviate the nausea and give me more prompt and better results than *veratrum* alone. In a very aggravated case of traumatic chorea from granular erosion of the cervix uteri which had resisted the usual routine remedies, fifteen drop doses of *veratrum* at intervals of fifteen minutes until three doses in all were given, afforded prompt relief. This was my first use of *veratrum* in rather heroic doses. With added experience in a similar case I would not hesitate to give thirty drops hypodermically. Dr. Norwood says, "We have seen no case of acute chorea that would resist or fail to be relieved of every symptom in 48 hours or less, by vomiting freely and continuing the *veratrum* in portions short of nausea, in combination with tr. of iron, etc." But it is in the toxæmia of eclampsia that *veratrum* has proven in my practice its most miraculous control. In all these cases I give a good mercurial purge, usually calomel, soda and podophylin, inject from 25 to 30 drops of Norwood's

veratrum at intervals of thirty minutes until I secure complete muscular relaxation, as complete as for the knife, by chloroform narcosis, when the convulsions will cease in all cases unless there is cerebral traumatism—a clot on the brain. I have reason to suspect this condition in the only case where the convulsions persisted, after the patient had been completely relaxed; but in a much less violent degree. A very short while elapses after the relaxation ensues, and some times coincident with it, nausea and vomiting occurs. I allow this to persist until I think the full physiological effect of veratrum has been exerted, and then with the same confidence of the railroad engineer, with his hand on the throttle, I reverse my therapeutic engine by injecting from  $\frac{1}{4}$  to  $\frac{1}{2}$  gr. of morphine, its antidote, and very soon have the satisfaction of having the vomiting and retching allayed, after having performed an important part of the very necessary work of elimination of toxins and also of seeing my patient quiet and comfortable.

This experience has been repeated and proven often enough to inspire me with the greatest confidence in the power of veratrum viride to control the terrible paroxysms of eclampsia, and also my own control over veratrum. But does *not* this wonderful controlling power suggest eliminative action also? If the fever is the expression of the presence and effects of toxins and the expulsive effects of the cells to rid the system of these invaders, how can an agent by simply controlling cardiac and arterial action, aid or effect a cure by that power alone? We can see how the nervous and muscular system is relieved to a great extent by lessening vascular tension, but to cure a case with veratrum viride demands that it shall possess marked eliminative as well as antidotal qualities. Does it not, in fact, possess such qualities? Dr. Abbott, of Chicago, says the "great value of veratrum viride as a remedy for fevers and for such toxæmias as eclampsia lies in its possession of the following characteristic powers:

"1st. v. v. lowers fevers, quells abnormal rapidity of pulse, opens all the doors of elimination and relaxes vascular tension.

"2nd. Its safety lies in the fact that it causes nausea, etc., when given in doses too small to cause dangerous weakness of the heart.

"3rd. By relaxing tissues and increasing the elimination of solids and fluids by the kidneys, it provides for its own elimination and that of any other toxine that may be in the system."

"Veratrum is the only remedy for continuous abnormal vascular tension. The prejudice against it is difficult to comprehend."

May it soon cease altogether and let this gift of God perform its wonderful mission of healing.

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#### TUBERCULAR PERITONITIS.

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H. L. WILSON, M. D.,

JORDAN, S. C.

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The subject of the paper which I will read before you to-day is Tubercular Peritonitis; a condition which is frequently met with particularly in children with tubercular family history. The infection is by the bacilli circulating through the blood or by extension of the tuberculous inflammation from other organs, though the condition may be a primary one. We have it in the acute and chronic forms. The former may be due to general milliary tuberculosis; or to perforations from nearby organs—frequently from the pleura, and in adult females often from the fallopian tubes, and in both sexes from the appendix. In adults we find it occurring oftenest between the ages of twenty and forty, after which it is much more rare. It occurs oftener in females than in males, the negro race being more prone to it than the white. Sometimes the onset is sudden with severe symptoms: fever, pronounced con-

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\*Read before the Clarendon Co. Med Society.



stitutional disturbance, pulse small and rapid, abdominal pain, nausea and vomiting, and there will likely be a frequency of thin stools. Temperature varies. It may be only slightly elevated or may be as high as 103 to 104, with early signs of anemia, emaciation and typhoid condition. We are likely to have the symptoms of effusion with a suppurative type of fever. In some instances the acute symptoms are absent giving only slight local and general symptoms: low fever, anemia, slight abdominal pains, as in the history of a case that I will present further on. When we come to diagnosis, unless we can determine as to tuberculosis in other organs, it presents some difficulty. A tubercular family history would aid us some: fever with a tumor, especially if it be a transverse one and elongated would be a diagnostic point of great value; and in case all of the organs from which you might expect infection could be excluded the mucus from the rectum and the urine should be examined for the tubercular germs. We would have to differentiate from internal hernia in which we have the sudden attack, pain local and in paroxysms, absolute constipation in a few hours, nature of the vomited matter, tympanites, but no ascites. From cancerous peritonitis in which we have the tumor growing slowly, a gradual obstruction of the bowels, and the age of patient, this being in older subjects. From enteritis by the frequent mucous discharges, the absence of tumor or ascites, no tubercular lesions in other organs. The treatment would, of course, suggest itself to you. There are some cases, those of a purulent nature, that would be purely surgical. The claim is made by some that all cases should undergo a laparotomy with possibly the exception of the acute cases of milliary tuberculosis.

I will now present the history of a case which was rendered more interesting because of a difference of opinion among the doctors who saw it, which, as you all know, occasionally happens. I was called to see D. P. White, male, age about four years. Found him pale, anemic, small pulse, temperature 100 8/10, abdomen

tympanitic with an elongated tumor extending from the umbilicus upward and outward to a point under the ribs on left side. His parents gave a history of an intestinal derangement of some six or eight weeks, which they attributed to worms and had given anthelmintics quite freely. I diagnosed the trouble as a peritoneal one. Some days later he was brought to my office. I called in a brother physician and he confirmed my diagnosis of tubercular peritonitis. The father wanted a diagnosis of appendicitis. I assured him that it was not, and put the child on an anti-tubercular treatment with rather an unfavorable prognosis. Learned next day that he had taken him to a neighboring town to a physician who diagnosed a purulent appendicitis and appointing the following day to open up the abdomen and evacuate the pus with, of course, the probability of a prompt cure. The physician who saw the child with me attended the operation. Upon opening the abdomen, they were greeted with the peritoneum rolling up into the incision studded with the tubercle—drainage was put in and the incision closed. Instead of the irritation to the peritoneum acting as a cure as it is said frequently to do, the tubercular process seemed lighted up to fresh activity and a perforation of the intestines in a few days was the result, with the fecal contents of the bowel pouring out through the wound. I saw the child afterward in visiting another member of the family. It lived some three weeks, finally dying from exhaustion. This in my opinion, was a case in which tympany was mistaken for purulent exudation.

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## SPECIAL ARTICLES.

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### HISTORY OF THE ROPER FUND.

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W. PEYRE PORCHER, M. D.

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(Read before the Medical Society of S. C. of Charleston Co. at the opening ceremonies of the new Roper Hospital, Feb. 19, '06.)

On a tablet over the board room of the old Roper Hospital occur these words:

This institution was commenced in 1850, and

completed in 1852. Thomas Roper bequeathed real estate to the value of \$30,000 in trust to the Medical Society of South Carolina to receive the interest and to invest the same, until a sufficient sum had accumulated, or aid received from public and private benefaction to erect and sustain a public hospital. The donation was received in 1845.

In 1849 the City Council of Charleston, with the Hon. T. Leger Hutchinson, Mayor, in order to sustain and perpetuate the noble and beneficent views of Mr. Roper, gave \$20,000 and land for the erection of a hospital.

In 1851 the City Council of Charleston, with the Hon. John Schnierly, Mayor, in behalf of the upper wards recently attached to the city, gave \$6,000 to complete the building. In December, 1851, the Legislature of the State of South Carolina gave \$10,000 for the use of the institution.

As appears above, the bequest from Mr. Roper, the City Council and the Legislature amounted in all to \$66,000. It now remains to be shown how the fund increased so greatly under the care of the Medical Society that they were enabled to build the Hospital at cost of \$26,400, pay the expenses of repairs, and running, and the cost of rebuilding it after the earthquake, and still have remaining at the inception of the new Hospital a sum nearly equal to \$200,000 out-side of the real estate.

It will be seen that the original bequest of Mr. Roper was only a nucleus to which many large bequests were added, both by the State and city, and also by private individuals. We must now show in detail what part the medical profession played in husbanding and increasing this fund so that to-day we are enabled to build this magnificent institution and to take charge within its walls of the entire sick poor of the city without asking in return anything except the actual cost of running it.

It is almost impossible to give an idea of the continuous work and unselfish devotion which the medical profession gave to this Hospital, the innumerable meetings of the whole board of trustees, the long and minute memorials sent to the City Council, and to the Legislature, the daily visits of the visiting committees, all without a cent of reward. The minutes of the board give us only the barest intimation of the enormous amount of work done. Very often the meetings of the board were held daily and generally weekly, but all during the erection of the building and the period of the war, the meetings were called just as often as any question arose which might be brought before them, even if it was only the purchase of a set of splints. At times the good nature and self-abnegation of the physicians and surgeons would rebel when they were allowed only a portion of the small fees which were paid by students for their hospital instruction, but they had determined to build the Hospital and to carry out Mr. Roper's benevolent intentions, and no amount of effort or self-sacrifice was to be spared to accomplish that object, and to give the paupers of the city every benefit which could be derived from the advanced medical science of the day. Of course, during the war the blessings of this institution were enhanced a thousand fold, because the sick and wounded soldiers had then a refuge, and the aid of their

home physicians and surgeons, and the people appreciated this fact, as it is shown in the minutes that wines and liquors and luxuries and necessities of all kinds flowed into the institution in an almost uninterrupted stream. The house surgeons then as now gladly served their terms for the amount which they could learn out of it, and the modest honorarium of \$50 per annum. Subsequently the visiting surgeons and physicians received from \$300 to \$400 per annum, except when the building was leased to the city, when they received as much as \$600, but all the other visiting committees, etc., did their work without fee or reward except the knowledge that they were working for sweet charity alone, and had contributed their share towards the advancement of the medical profession and maintenance of the Roper fund.

It must be stated that previous to the Roper bequest in 1845 the Alms House or Poor House, as it was then called, constituted the only refuge for the sick poor of the city. This was a large building near the corner of Mazyck and Queen streets, which was afterwards converted into the colored wards of the Roper Hospital. The earliest minute book recording the bequest of Mr. Roper and the receipt of it by the Medical Society was lost and has never been found; so that we have nothing more than the will of Mr. Roper to record that incident. In this will it was stated that the Hospital was not to be built for fourteen years after the bequest, unless earlier they may be sufficiently enabled from their adequate means to erect, maintain and regulate a hospital for sick and poor without regard to complexion, religion or nation. It will be seen that Col. Roper designed his Hospital for the reception of all. The sick poor from all parts of the State are equally entitled to its benefits and hence, the Legislature was asked to contribute to the erection of the building.

A memorial was sent to his Excellency, Governor Seabrook, setting forth the conditions and objects of the fund and asking for a yearly appropriation to assist in building the Hospital. One memorial was sent by the trustees and one by the commissioners of the Poor House to the City Council in order that the two charities might be amalgamated. The City Council recommended that the sum of \$6,000 or \$7,000 asked for by the board of commissioners of the Poor House be granted them, which, together with the application of the fund known as the Coffin fund, and the estimated value of the materials that compose the present building will enable them to erect an edifice more worthy the city and better adapted to the purpose designated. They also recommended that \$20,000 and \$1,000 annually thereafter be appropriated in order to enable them without further delay actively to carry out the benevolent objects of the donor. The committee also advised that the fund and real estate of the Roper bequest be hereafter released from all taxation.

Another memorial was sent to the Legislature and each member of the board was asked to solicit subscriptions from private individuals.

The lot on the corner of Queen and Mazyck was given by the city and also a portion of the lot belonging to the Medical College. This latter with the proviso that the College should have the use of one ward in the Hospital

On January 19, 1850, Mr. Jones was elected



architect for the building and the Legislature was again memorialized. On July 10th, of the same year, a contract was entered into with Mr. J. M. Curtis to build the hospital for \$26,400, and piling was at once begun on the lot. In November 29th the trustees called attention to the flattering prospects from the results of their year's labor. The total sum received was \$17,302.33, of which \$13,500 was a part of the \$20,000 which had been donated by the city. Another memorial was sent to the Legislature and it was proposed at that meeting to elect a secretary and treasurer and to pay him for his services. Dr. W. T. Wragg was elected for this office in December, 1851, with a salary of \$300 per annum. The year 1851 was a dark year for the fund, for we find that by the end of that time the appropriation by the city was nearly all gone and private subscriptions were few and far between.

As has been said above, the poor of the city, previous to 1845, had always been cared for in the Poor House, on Mazyck street, and this was under the care of a board of commissioners, who no doubt gave their services free, and were exceedingly jealous of their dignity, and great care and consideration had to be used in approaching such a delicate subject as a change of any kind. In fact it is recorded in the memorial of the Roper Hospital board to the City Council as follows:

"Your petitioners now approach the most delicate part of the application, for they think that they have shown that the granting of the prayer shall be a saving of expense to the city, since it will obviate the necessity of erecting appropriate buildings and wholly endowing them. This is the giving up of the appointment of commissioners and officers to an institution to which they will have so largely contributed." In reviewing the minutes it is amazing to see the amount of arduous labor, the endless number of meetings, the time and trouble, which was freely devoted to this subject by the board of trustees of the Roper fund. The secretary must at least have devoted the best part of his life to it, as he served as secretary for thirty-five years, and he had the proud satisfaction of knowing that at the end of his labor, besides building the hospital by great circumspection and good judgment, the fund had more than doubled the original amount. The building committee had so much difficulty in raising funds to carry on the work that they were obliged to suspend all work for a time; the contractor guaranteed to protect the work so far done from injury by rain, etc., and also to resume the work in one week after the trustees were in possession of sufficient funds to warrant them in doing so. What was known at that time as the upper wards of the city had not been a part of the city proper, and was, therefore, incorporated, and they, having equal privileges for enjoying the use of the new building, were asked to contribute their quota to it. The City Council on that account appropriated \$6,000 for the completion of the building, and work was resumed as agreed upon by the contractor in one week thereafter. By the addition of this amount the fund now amounted to \$25,960.61.

This \$ 6,000 was advanced as a loan, and, in addition the City Council appropriated \$1,000 annually to assist in running the Hospital when it

should be completed. It must not be supposed that the City Council made these appropriations without due regard for its own interest, they were only paying a comparatively moderate amount for the care of their entire sick poor, and at the same time deriving the benefit of the Roper bequests and all subsequent bequests of which, as we shall see, there were not a few as proved by the phenomenal growth of the fund. It is here recorded that \$1,500 were contributed from private sources, but the names of the individuals who made the contributions are not given. It is mentioned at this time that \$7,000 was left to the institution by a private individual, but his name is also not given.

Dr. Dickson offered to give a series of lectures for the benefit of the fund, and Dr. Simons arranged to give a concert. In another memorial to the Legislature it is stated that "a proper plan having been adopted, and contracts entered into, a noble building of imposing appearance and spacious room, with all the aids that modern skill has brought to bear upon the comfort and sick and suffering creatures, has risen into existence, and stands in readiness to dispense its healing blessings as soon as public generosity has been aroused to such an understanding of its wants as will stimulate it to acts of Heavenly charity. The amount already expended, together with the small sum still requisite for completing the furnishing of the building, amounts to about \$40,000."

"The Hospital, so erected at a cost so much below what it could now be contracted for, is capable of accommodating about one hundred patients. The greater portion of these will be accommodated for in the large wards, where, as in all hospitals, many sick will be gathered together. But there are also provided a certain number of smaller wards, into which those laboring under loathsome or contagious diseases can be kept entirely aloof from the others, and altogether, the arrangements are such as to ensure for the patients seeking its charitable aid, the greatest amount of comfort with the least amount of annoyance possible in such institutions." In December, 1851, the Legislature appropriated \$10,000 for the benefit of the Hospital.

In January, 1864, the securities, not including real estate, amounted to \$28,302.06, and total donations to date, to \$37,400, but still they were not able to open the hospital, although it was completed and almost entirely furnished, but the total income from rents, interest, etc., amounted to only \$3,116.14 per annum. The city was at that time paying \$4,000 a year for the care of their pauper patients, therefore the City Council was again memorialized, because, by a small increase to the annual income of the trustees the magnificent new hospital could be opened, and all the poor of the city cared for in keeping with the will of Mr. Roper.

"In March, 1834, the trustees, with honest pride invited the attention of the public to the statement that a property which, in 1846, was represented by four houses and lots bringing in a yearly income of \$2,100, in 1854 represented by these same houses, and, in addition, a magnificent hospital, built upon a lot of land worth at the lowest estimate, \$7,000, and the invested sum of \$17,300. In other words, by judicious and laudable exertions they have, in the course of less than eight years, increased Col. Roper's

bequest by the handsome amount of \$17,300 in bonds and stocks, and by one of the finest Hospital buildings in the country."

Finally, in April following, furnishings were ordered for the hospital, and it is interesting to note that no mention or allusion is made to any sterilizers or preparation for antiseptics. In fact, the list reads more like the requirements of a hotel than a hospital.

In July, 1854, memorials were sent, both to the City Council and to the Governor of the State, setting forth the condition of the hospital, the state of the funds and the need of further assistance to open the building. As said above, these appeals were made to the Legislature because, by the terms of the will, the hospital was open to every class of persons from any portion of the State or from any quarter of the globe.

It was not until September 7th, 1854, or four years and two months after the work was commenced, that the building was opened, and then only for a short period, because yellow fever had become epidemic in the city, and its doors were again closed November 18th following, because of want of funds to keep it open. In December, 1854, there was only \$2,518 left in the treasury, except real estate and securities. It is recorded, however, that throughout the entire epidemic many contributions of money and supplies were made to the hospital, and that the physicians all gave their services free of charge, although the labor was arduous and dangerous. One of them was stricken with the disease while on duty and narrowly escaped with his life.

In 1855 it is recorded that the Poor House was turned over to the city and became a part of the Roper Hospital. Legacies to the amount of \$9,200 had been left to the fund and also donations to the amount of \$37,000—total securities amounting to \$45,052.16—and a contract was made with the city for \$5,000 per annum and \$3,000 by the Legislature. January 18th, 1856, the hospital was finally opened, and the attending physicians and surgeons were elected. This was just five years and six months after the construction of the building was commenced. It is needless for us to point out the extraordinary contrast between that and the rapidity with which this new hospital has been built and put into operation. This is all the more striking when we compare the relative size and nature of the former and the present building.

It is of interest here to mention that house physicians must have either been scarce or shy of their services in those days, since it is stated in a special report that advanced medical students rather than graduates would be selected. "The committee have been induced to make these suggestions from the difficulty at present exhibited—not having at present a single candidate qualified according to the present rules, and believing young men, not graduates, by their talents and attainments may prove more available and really useful than graduates, and it can scarcely be supposed that the trustees would elect any one without being fully persuaded of his fitness for the duties required." In the light of the present requirements these words read like a page from very ancient history.

Under a contract with the City Council, dated February 12th, 1858, the sick poor and temporary and transient insane were cared for to the satisfaction of Council until the commencement of

the war, when the Hospital was thrown open for the reception of the wounded and sick soldiers, and this continued until August, 1863, when the building became unsafe on account of the enemy's shells and the soldiers and civilians were removed to the school building in Morris street until March, 1864, when that building was taken possession of by the Federal authorities. The trustees then removed their sick poor to the Alms House, on Hampstead Mall, one wing of which was loaned by the commissioners for that purpose.

From February 3rd to November 11th, 1865, no meetings were held on account of the evacuation of the city, all buildings being confiscated by the enemy. After this date a portion of the hospital was restored to the trustees and in November, 1866, it was turned over entirely and a rental of \$2,300 was paid for its occupancy. Stores, medicines, etc., were supplied from the Freedmen's Bureau, which enabled the trustees to keep the building open from March 5th, 1865, until the City Council were enabled to renew its contract with them, which they held previous to the war. The City Council persistently refused to renew this unless the hospital building should be leased to them entirely for a period of years. The legality of this was denied to them in long opinions by Messrs. Simons & Simons and the Hon. C. G. Memminger. In July, 1869, realizing the urgent necessity for more revenue from which to run the institution, the following circular was issued and published in the daily papers in Charleston and Columbia for three months:

"The trustees of the Roper Hospital, of Charleston, an institution under the direction of the Medical Society of South Carolina, have appropriated a part of their commodious buildings as a *Maison de Santee*, or private infirmary. There must exist a number of persons suffering under medical and surgical diseases in sparsely peopled sections of the State to which medical access is difficult and where the necessary conditions for cure at home cannot be obtained, to whom a regular hospital and modern appliances would be a great accommodation. To such persons the trustees offer their fine accommodations with board and lodging, nursing and the best medical and surgical attendance, at the moderate charge of \$12 per week, the profits derived from this source to be expended for the support of the destitute sick. Your recommendation is respectfully solicited in this charitable work. Application for further information, or for admittance, to be made to Dr. W. T. Wragg, secretary and treasurer of the board, No. 21 East Battery, Charleston."

The following advertisement was also published:

"The public are respectfully notified that a part of the Roper Hospital building has been organized as a private infirmary for the treatment of patients in the city and throughout the State who cannot be conveniently attended at their domiciles. The trustees are prepared to receive both medical and surgical cases at the Roper Hospital, where the best medical and surgical treatment, with board and nursing, will be provided for the sum of \$12 a week. Apply to Secretary and Treasurer Dr. W. T. Wragg, No. 21 East Battery.

It is here shown that a part of the Hospital



was used as a private infirmary and the funds derived therefrom were devoted to the sick paupers cared for in the other portion.

On December 2nd, on account of the insufficient interest received from the fund, a resolution was offered that the hospital should be closed for a limited period until the funds might accumulate sufficiently to place the hospital upon a permanent footing. This was very much opposed by many members of the board, but finally after prolonged legal discussion permission was obtained from the Court, and it was determined that the hospital should be closed on the 1st of August, 1871, and that a fee of \$292. be paid to the attorneys for their work, and the salaries of the physicians and surgeons, amounting to \$875. each, be paid as soon as the interest should accumulate sufficiently to do so. It was also decided that the salary of the secretary should be restored to \$400 per annum. On January 3rd, 1873, a resolution was offered to lease the building to the city for a period of ten years on condition that the property would be kept in good repair, and free of rent. This arrangement was agreed to by the City Council, and a lease was signed on March 4th, 1873.

At the expiration of this lease a new agreement was entered into, by which the city leased the Hospital for five years at a nominal rental of \$500 per annum, and agreed also to keep the property in repair. In the meantime, however, and all during the previous ten years, the Roper fund had paid taxes regularly on all its property outside of the hospital proper. This amounted to nearly \$600 per annum, therefore the city virtually had the use of the buildings for nothing except the cost of repair.

On May 30, 1885, the fund sustained its heaviest loss in the death of its faithful custodian, Dr. Wm. T. Wragg, who had been secretary and treasurer of the fund from its incipency to the time of his death and had preserved all the securities of fund after the evacuation of the city as though they were his private property.

In 1886 the hospital was wrecked by the great earthquake, and although the City Council had contracted to keep the building in repair, which lease did not expire until 1888, they declined either to repair the building or to renew its occupancy on the ground that the wreckage was due to the visitation of God. The board were also advised by their solicitor that it would not be expedient to take any steps to compel the city to repair the hospital until the expiration of their lease in 1888. Meantime through the efforts of Dr. Bowditch, of Boston, and other persons, an earthquake fund had been raised for the benefit of the only hospital in this city at that time.

On February 25, 1889, it is recorded that a written communication was sent to the City Council demanding a settlement of the hospital claims for repairs, that the matter had been referred to the city attorney, and the latter had requested that if the board would make some proposition he would be glad to consider a compromise of the claim.

It was then agreed that the solicitor of the board should confer with the city attorney in relation to the proffered compromise of the claim of the board against the city upon a basis of one-half the cost of repairs.

Under the advice of Solicitor Simons the trus-

tees finally accepted the amount of \$125 offered by the city in lieu of all rent due for the Roper Hospital and the earthquake damages were repaired by the trustees at a cost of \$11,172.35.

These repairs became obligatory because the building would have gone to rack and ruin had the trustees waited until the expiration of the contract with City Council, in 1888. The chairman of the earthquake relief fund in Boston expressed his opinion that a portion of that fund was intended for the hospital in Charleston—the only hospital at that time was the Roper Hospital—and if it was not so expended it would constitute a diversion of the fund." In spite of this fact, however, and also of the fact that the Poor House and lot had been turned over to the Roper Hospital, the contract "to remain in force as long as the agreement shall be mutually carried into effect," the contract was broken, the Poor House torn down, the lot sold and the proceeds, with a considerable part of the earthquake fund, was invested in the City Hospital, which was built on this site. As a result of this the sick poor of this State and city were deprived of this great charity and the extensively repaired building was left unoccupied for eighteen years and nine months, until January, 1904, when the Medical Society determined to build a hospital which would be a credit to them and would give to the people of this city and State the benefits of this great charity once again.

The result of their efforts you have now before you, and I have the great honor and pleasure of congratulating you upon the possession of a magnificent plant, of which not only the people of this city and State, but the medical profession, may well be proud. I now leave the matter in the hands of the chairman of our building committee, Dr. R. S. Cathcart, who will explain to you the method by which this wonderful result has been accomplished.

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## THE NEW ROPER HOSPITAL\*

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R. S. CATHCART, M. D.

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Mr. President and Gentlemen of the Medical Society of South Carolina: The movement to give the City of Charleston better hospital facilities, and to utilize the Roper fund for this purpose, began in December, 1903, when Dr. Porcher, in his inaugural address, as president of the Society, called attention to the Roper fund, how it had remained idle and the poor and sick of the city deprived of its benefits, since the abandonment of the old Hospital on Queen street in 1886.

This fund has been held and guarded as a most sacred trust by each member of the Society, and it has always been our most earnest wish and effort to carry out the terms as set forth in the will of Mr. Roper.

This address of the president and the urgent need of a modern hospital being appreciated by

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\*Read before the Med. Society of S. C. of Charleston Co. at the opening ceremonies of the new Roper Hospital, Feb. 19, 1906.

every member of the Society, stimulated them to make renewed and determined efforts to re-establish the Roper Hospital.

Acting on this incentive the Society appointed a committee of nine to formulate plans to accomplish this purpose. The committee, after organization, called on Mr. Rhett, the newly elected Mayor, and informed him of the lack of hospital facilities of the city, and also that the medical institutions of the city were being conducted without medical representation. He appreciated our motives and arranged for a joint meeting with a committee from City Council. After several conferences with this committee extending over a period from December, 1903, to June, 1904, a memorial was sent to City Council from the Medical Society of South Carolina, offering to build a Hospital on the site of the City Hospital with the Roper fund and to contract to take care of the sick poor of the city for a certain fixed sum per annum—also including the city dispensary service as an outdoor department. This was adopted by City Council, and the Medical Society then appointed a committee of five to carry out the purposes of the memorial and to act as a building committee. From this period, June, 1904, to December, 1904, there were many conferences with a committee appointed by City Council, of which Alderman Leiby was chairman, before a form of contract, the plans of the new Roper Hospital, etc., were agreed upon, and the Mayor instructed to sign a deed transferring the City Hospital property to the Roper trustees. It was in March, 1905, before we had possession of the old buildings and the wrecking of them started.

On May 28, 1905, the first work was commenced on the present building, and to-night, Mr. President, February 19, 1906, we wish to turn over to the Medical Society of South Carolina, the new Roper Hospital, modern in every detail of arrangement, surpassed by few in the country, equalled by none in the South, a building in which we think the medical profession and every citizen of Charleston should take pride. Over two years since the appointment of the original committee of nine and eight and a half months since actual construction began.

The Hospital consists of five buildings, and is constructed of brick, with tile roof, with the exception of the kitchen and laundry building, and stable and morgue building, which are of wood and stucco.

It has accommodation for over two hundred patients, provision being made for the separation of the races, (a condition not met with in the hospitals of the North,) separation of the sexes of the races, separation of diseases, viz.: 4 medical, 4 surgical, 2 tubercular, 2 insane, 2 infectious, making in all fourteen wards—besides children's rooms, maternity rooms, private rooms, sleeping quarters for house staff, superintendent, druggists—white, help offices, etc. The number of rooms in the building, not including closets, is 162. Each ward or department has separate linen and supply closets, diet kitchen, dining room, bath and toilet. The porches on the west of all wards are inclosed with glass and steam heated.

The offices of the outdoor department are located in the basement of the Lucas street building.

The Riverside Infirmary has been remodeled

inside, the rooms made much smaller, so as to give accommodation for thirty private patients. The former building accommodated eighteen.

There are five surgical operating rooms. The general operating room in the main building, dedicated to the memory of Dr. R. B. Rhett; private operating room in the Riverside department, accident room, near ambulance entrance, for police cases; eye and ear room, room for outdoor clinic.

The entire plant is heated by steam from a 125-horse power boiler, which also runs the machinery of the laundry, supplies the kitchen with steam for cooking, heats the hot water supply of the building. The hot water supply is from two tanks of 600 gallons each, located in a pit beneath the students' stairway. The plumbing work in the building is of the best, the most modern fixtures being installed in all departments and operating rooms.

The kitchen and laundry are models of their kind, and are equipped with all modern appliances.

The stable, morgue and carpenter shop are in one building, in the northwest corner of the grounds. This building is conveniently and comfortably arranged, supplied with heat and electric light.

The kitchen, main building and Riverside department are connected with a covered corridor, enclosed with glass and steam heated.

The ventilation of the Hospital is provided for from each room by shafts, which lead to a common shaft in the cupola. In these shafts are steam pipes to create a draft, the foul air from each department being taken out in this manner.

The buildings are lighted by electricity from the street current. It is wired so that the superintendent has control over the lights in the whole plant from a switch board in the office. In the wards the reflectors are placed beneath the lights. This is to give a general glow over the room, at the same time protecting the patients' eyes.

There are two stairways in the main building, built of iron, with slate treads and platforms. One in the front of the building, around the elevator shafts; the other in the back, opening on the yard. This is for the students and leads to the entrance of the operating and lecture rooms.

The building, while not absolutely fire-proof, has ample fire protection. Brick walls separate all departments; each are provided with fire plugs for hose and iron fire escapes on the porches.

The infectious pavilion, which is separated from the main building, has accommodation for twelve patients, six whites and six colored. It has rooms for isolation of nurses, store rooms, etc. This has been one of the needs of the city for many years, and should prove of vast benefit to its citizens and business interests.

The condition as existed before, of having consumptives in the medical wards, is, without doubt, responsible for many new cases of that disease. We hope by having them in a separate ward in this building to be able to do more for them; at any rate they will cease to be a menace to the health of other patients. A patient will not come to the hospital and recover from typhoid fever, for instance, and leave with consumption.

The buildings have been wired for the installation of a private telephone system of nineteen



stations, connecting all departments with the superintendent's office.

The building is completed with the exceptions of the elevators, which were unavoidably delayed, and are being installed at the present time.

Each member of your committee has worked hard. They realized fully at all times their responsibility. The work has been a pleasure to them, first, because they knew that the hospital would benefit the sick and maimed; second, they thought they were working for something that would help Charleston, and last, that they were helping to place the medical profession in the position that it should have occupied in the management of the medical institution of the city.

## COUNTY NEWS.

### Charleston.

The most important event of recent occurrence in Charleston was the opening of the new Roper Hospital. On the night of Feb. 19th, a special meeting of the Medical Society was held in one of the wards of the new hospital for the purpose of receiving from the building committee the completed building.

Addresses were delivered by the mayor of the city, Mr. R. G. Rhett; the president of the Medical Society, Dr. C. M. Rees; and the chairman of the building committee, Dr. R. S. Cathcart. A full history of the Roper Fund was prepared and read by Dr. W. Peyre Porcher. Dr. J. S. Buist moved the acceptance in an able impromptu speech. At the conclusion of the ceremonies several thousand citizens who were the guests of the Medical Society were given an opportunity to inspect the elegant structure.

On Feb. 27 the student body of the Medical College assembled in the surgical amphitheatre where they were met by the Dean of the Faculty; several members of the faculty; the chairman of the Board of Commissioners, Dr. T. G. Simons; and the chairman of the building committee, Dr. R. S. Cathcart. After welcoming the students to the new hospital the Dean, Dr. F. L. Parker, introduced Dr. T. G. Simons, who spoke as follows:

"In behalf of the commissioners of the Roper Hospital I welcome each of you to-day. At the recent opening ceremonies you heard of the grand, unselfish work of those of the profession who, in past decades, built and maintained the old Roper Hospital; all honor to their memories. They deserve the gratitude of all of us for their devotion to a sacred trust. High ideals are not of times, and I will allude to a more recent instance and ask to be allowed a personal mention. To-day this modern Hospital, so well equipped and so fitting in every detail of construction, is the fulfilment of the untiring, unselfish devotion chiefly of one man, who, in spite of opposition, with a clear conscience and unfaltering zeal, overcame difficulties and made secure all the benefits you to-day enjoy.

"I allude to Dr. Robert S. Cathcart.

"When Mr. Thomas Roper in 1843 or 1845 bequeathed the legacy to the Medical Society of South Carolina, a trust to erect and maintain

and regulate a Hospital of such dimensions as they, in their better judgment, may direct for the 'permanent reception or occasional relief of all such sick, maimed or diseased paupers as need surgical or medical aid, and whom without regard to complexion, religion or nation, I would they should admit therein. The site of the said Hospital or infirmary, to be at or near Charleston.'

"Such, gentlemen, is the origin of the trust fund. Other donors have given by legacy and otherwise to the fund, but it was due to the broad spirit of love for his fellow man that was in the heart of Thomas Roper that the fund had its beginning. This new building has a large sphere of usefulness besides the God-given feature of charity. 'I allude to the education of physicians and nurses, who by their training and skill will carry out from its portals benefits to the sick and the suffering wherever such educated physicians and nurses shall go. I deem it but right that material for instruction should be drawn from its wards and its wide clinical facilities in special lines of treatment in the outdoor service; from these sources fully informed physicians shall go forth to earn the love and appreciation of their patients and also to reap material benefit for themselves.

"I would not have you to acquire alone the experience that will enable you to diagnose and treat disease, but also to acquire an ethical culture and regard for your profession as a most sacred calling.

"To learn the amenities and tender considerations due from the true physician to his patient, a gentle dignity of word and act, these make the well rounded physician of tact and professional accomplishment. I would urge you to begin here in these wards the study of the consideration due the sick, even the pauper sick; many enter here the victims of misfortune, and not always here from errors and vices of their own; all need help and encouragement, and kind words and gentle, firm manipulation of their cases, rather than indifference to their feelings. Nor need the fear of social equality burden your thoughts. Sickness is a great teacher. I can recall the dignity of Dr. Eli Geddings, and the master hand of Robert Kinloch, with gentle firmness in the attention to the sick paupers regardless of color, creed or nation.

"Instruction from their cases is right, but no untimely remark should be uttered at their bedside. The golden rule is applicable to the humblest sufferer. Thackeray has given one of the grandest pictures of a perfect man in Col. Newcombe, and his code of ethics was 'be a gentleman,' and more recently a rare type existed in Robert E. Lee, 'Anax Andron,' a king of men, whose watchword was duty; these men were grand exemplars of gentle dignity. Medical colleges do not teach medical ethics, and often the commercial spirit is too evident in physicians who, in their desire to succeed and acquire wealth, forgot the true dignity of the profession and its claims upon each member to aid each other in all professional advance for the benefit of the profession, and its claims on each of us to maintain ethical relations to the craft. A physician's individuality should be most apparent. Nor should we decline to direct the public in

matters on sanitation and hygiene. These present a wide sphere of usefulness to the educated physician and, remember, as a citizen you can advance the material interest of your community—for the more prosperous the community the greater your prosperity will be."

Dr. R. S. Cathcart, chairman of the building committee was then introduced by Dr. Parker. Dr. Cathcart spoke very instructively and entertainingly of the arrangement of the wards, the separation of the races, sexes and patients suffering from different diseases, and called attention to the sanitary arrangements of the Hospital. He spoke of the operating theatre, the clinical lecture room, the outdoor department, the separate rooms for the use of medical and surgical patients, the central dispensary for the distribution of medicines to the sick poor of the city, the emergency operating room for police cases, and the contagious wards, where persons afflicted with contagious diseases can be isolated. The address was an able one, and the audience gave close heed to the words of Dr. Cathcart. After the conclusion of the opening exercises the regular college exercises were resumed.

#### Greenwood.

The physicians of the city of Greenwood some time ago by some means began to entertain at their home or in their offices the physicians of the city. Sometimes the refreshments were light at others a splendid feast. Our meetings were found to be pleasant. We really found that we were fast friends and we didn't know it. We resolved to make our meetings permanent. Dr. J. B. Hughey was elected President; Dr. J. C. Harper Vice-President, and Dr. G. P. Neel Secretary. To perpetuate any organization we believed it to be essential to make it of permanent benefit as well as pleasant. We therefore selected the subject of *materia medica* and therapeutics for study. About six months we devoted to this subject exclusively, and later we included the field of medicine. We now meet every Thursday evening at eight o'clock promptly and listen to a carefully prepared paper from one of our number, which is fully discussed by all of the members present. We find that we can be free in our differences, criticise freely and frankly, express our opinions however divergent, and cement our friendships. Rarely is one of our number absent, and never has one failed to perform his duty in regard to the paper. The reader is assigned alphabetically, and the subject is whatever the body thinks of greatest interest at the time. Just now pneumonia is of greatest interest and the subject from which our opinions diverge. We can find no common ground upon which we can all agree as to the treatment of the great disease, and from present indications we will not; but one thing is certain, we will know each others ideas, and as a corollary, we are quite likely to know what is known of the subject. Opinions, orthodox and heterodox, are freely presented to be mercilessly criticised. They all go into the crucible.

I have written in this way of our meetings to give if possible as complete an idea as possible. Our plan is by no means perfect, and will in all probability undergo radical change in future. We

have no grievances to adjust and hope never to have. It seems that all matters of this kind find their own adjustments. We are working for each other's welfare as well as the first personal pronoun—the altruistic principal. To whatever of benefit the one has pertaining to our craft the other has free access.

Perhaps it would be better to assign each man a department of medicine and let him prepare himself for it and give to his brethren the benefit of his research, as is done in some other places, and may later be adopted, but at present we find our plan to work admirably well.

Our Association in obedience to your request for news has instructed me as the secretary to give you an account of our meetings. In this very informal way I have done so.

G. P. NEEL.

#### Kershaw.

At a call meeting of the Kershaw Co. Medical Association on February 26, 1906, the following resolution was passed:

That we revert to our previous fee for Life Insurance Examinations, \$5.00 for old line companies, that pay the fee and \$3.00 for Fraternal Assessment Companies where the Applicant pays the fee, and that the secretary be requested to notify all the Societies in the State and the Officers of the State Medical Association, requesting them to uphold us in this matter.

S. C. ZEMP.

### ORGANIZATION.

#### Fourth District Medical Association.

Pursuant to a call of the Greenville County Medical Society the 4th District Medical Association met in the hall of the County Society at noon on February 5th, 1906. The Association was called to order by Dr. C. C. Jones, Prest. of the County Society. Dr. J. W. Jervey by request explained the object of the call. On motion a committee of six, consisting of one member from each of the six counties of Greenville, Spartanburg, Oconee, Union, Pickens and Anderson were appointed to formulate a plan of procedure and report at once. The committee composed of Drs. Jervey, Wideman, Potts Tripp and Hines reported as follows: The organization shall be known as the 4th District Medical Association. All members in good standing in their respective County Societies shall be eligible. All others must be elected.

The Councilor of the district shall act as president.

The Secretary shall be elected for three years. A meeting shall be held annually on the 4th Monday in January in some County of the district, the expense of the entertainment to be borne by the County Society.

All papers read shall be handed into the Secretary to be published in the *Journal of the South Carolina Medical Association*.

Each member shall register in the regular register book of the County Society where the meeting is held.



The rules of the S. C. Medical Association Constitution in so far as applicable shall apply to this body.

There shall be no annual dues. The order of business shall be the same as that of the County Society. Each County Society shall appoint one member each year to read a paper for that County at the annual meeting. Voluntary papers also accepted and put upon the program.

All papers to be limited to 20 minutes duration. The choice of next place of meeting shall be last in order of business. We recommend that Dr. E. A. Hines of Seneca be elected Secretary for ensuing three years.

After the adoption of this report the new officers assumed their duties. The Prest., Dr. J. W. Jervey rendered excuses for the absence of Drs. Robt. Wilson, Jr., of Charleston, and O. B. Mayor, of Newberry, who were on the program and called for the paper by Dr. E. A. Hines, of Seneca on Bronchopneumonia. Dr. Hines' paper was ably discussed by Dr. T. T. Earle, of Greenville.

On motion the visiting physicians were granted the privileges of the floor. Interesting cases were called for and Dr. R. E. Hughes, of Laurens, reported case of rubber nipple lodged for some time in post nasal space. Dr. Boozer, of Laurens, reported similar case.

Dr. H. R. Black, of Spartanburg, reported an interesting case of a foreign body penetrating the abdominal cavity and subsequently passing out through the rectum.

On motion Dr. R. L. Hughes, Secretary of the Tri-State Medical Association, was invited to speak in reference to approaching meeting of that body at White Stone Lithia Springs, Feb. 27th and 28th. Dr. Wilson, of Spartanburg, in behalf of the committee of arrangements cordially invited the members of the 4th District Medical Association to meet with the Tri-State.

Dr. F. L. Potts invited the district association to meet in Spartanburg next year. Dr. J. H. Hamilton extended invitation in behalf of Union. Spartanburg was selected.

At this point Dr. W. C. Black of Greenville, was requested to read the paper he had prepared for the County Society on Appendicitis. Dr. H. L. Shaw had been appointed to head the discussion but the dinner hour had arrived and the meeting adjourned to the Blue Ridge Hotel. An elaborate course dinner was served and many happy speeches evidenced the pleasure of the members.

Those present and registering were as follows: L. G. Sarratt, Union; G. H. Bottum, Greenville; C. N. Wyatt, Easley; C. E. Rogers, Duncans; W. S. Pack, Greenville; W. A. Smith, Glendale; L. F. Robinson, Dacusville; J. E. Daniel, Greenville; J. R. Gibson, Inman; D. G. James, Greers; D. R. Norman, Fair Forest; E. W. Carpenter, Greenville; E. A. Hines, Seneca; Frank Lander, Williamston; J. W. Jervey, Greenville; J. F. Williams, Roebuck; J. A. Hayne, Greenville; H. L. Shaw, Fountain Inn; G. L. Martin, Greenville; A. R. Fike, Spartanburg; F. L. Potts, Spartanburg; J. H. Hamilton, Union; J. H. Allen, Spartanburg; W. C. Black, Spartanburg; C. E. Wideman, Pelzer; W. R. Dendy, Pelzer; J. R. Ware, Greenville; L. C. Stephens, Greenville; T. T. Earle, Greenville;

R. D. Smith, Greenville; G. T. Swandale, Greenville; G. A. Bunch, Spartanburg; W. Y. McDaniel, Taylors; H. R. Black, Spartanburg; C. G. West, Princeton; T. W. Bailey, Greenville; B. F. Goodlet, Travelers Rest; E. B. Hendrix, Greenville, Route No. 6; C. C. Jones, Greenville; J. B. Brown, Spartanburg; L. G. Corbett, Greenville; W. A. Sheldon, Liberty; W. A. Tripp, Easley; C. B. Earle, Greenville; G. DeF. Wilson, Spartanburg; Davis Furman, Greenville; Joe Earle, Greenville.

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## CORRESPONDENCE.

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### THE PROPRIETARY NOSTRUM.

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*To the Editor of the Journal of the South Carolina Medical Association:*

SIR:—

There is a great and righteous crusade now being conducted against the proprietary nostrum, and yet it must be admitted that the doctors have themselves alone to thank for the universal use of these abominations. For centuries past the accumulated therapeutical knowledge of the medical profession has been given away in direct disregard of the Hypocratic Oath which says "I will impart a knowledge of the art to my own sons and to those of my teachers and disciples bound by a stipulation and oath according to the law of medicine, 'but to none others.'"

The druggists would have been less than human had they failed to take advantage of the vast flood of experience which had been showered upon them, in fact, it might even be said that they were driven to it, since when the inestimable value of many prescriptions had been proven the laity demanded it in such large quantities that it amounted to wholesale compounding.

Who should be held responsible for this condition? Surely not the laity who were ignorant and not infrequently had been taught by the doctors the true value of the drugs; and certainly not the druggist because while in the majority of instances, perhaps, they used the knowledge imparted to them unwarrantably, still that knowledge had been derived from the doctors themselves and without any re-

strictions whatsoever. Therefore, manifestly, the doctors have no one but themselves to thank for this condition, and now it would be just as easy to stop a fire in a prairie after a long drought as to stop the indiscriminate and endless use of proprietary medicines. Besides that, a great many of them are elegant preparations and well adapted to certain conditions and are commonly ordered by the very men that they were intended to rob of their just incomes. The writer has only just been informed by a patient, with a look of glee upon his face, "that he had recently saved himself a fee by using a well known proprietary mouth wash and universal panacea," and he will continue to do this until the inflammation takes on a malignant or specific character, when he will wish that he had not trusted to it.

Now what is the most rational remedy for this abuse, for so it must be termed? Is it rational to continue to berate the nostrum makers—meanwhile we continue to furnish them with every particle of information in our power? Is it rational to suppose that the public will stop using these nostrums as long as they are offered them as they are, without any fee for examination? The doctors are the ones who should be instructed as to their best interest, because they constitute the fountain source of the trouble. Of course it is well to instruct the public also, but it is useless to instruct the public as long as the doctors continue to prescribe these nostrums. W. PEYRE PORCHER, M. D.

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## NOTES AND REVIEWS.

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### PRACTICE OF MEDICINE AND CLINICAL MEDICINE.

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JOHN L. DAWSON.

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#### DIPHThERIA ANTITOXIN EFFECTIVE IN SCARLATINA.

J. H. Lopez, *American Medicine*, Jany. 27th, '06, Philadelphia, states that in his experience early curative doses of diphtheria antitoxin administered in scarlatina abort the disease, curtail suffering and lessen the risk to the patient, one dose of 2,000 units being sufficient in the average case of sore throat due to bacterial in-

fection to effect a speedy cure. He also finds the serum equally effective in all anginas, be they scarlatina, tonsillitis, quinsy, etc., through neutralizing the toxins and reducing the fever and local congestion which contribute to the patient's suffering and the element of danger. There are no contraindications. Lopez says that it should be remembered that the largest quantities of serum the most severe cases may require, from 20,000 to 100,000 units, are not depressing to the heart, are not attended with any bad results or sequels and are without a single element of danger.

#### ANTS AS CARRIERS OF TYPHOID.

Mayer describes an experience with some laboratory mice which indicates that ants may carry typhoid infection. Ants had access to the cages of some mice infected with mouse typhoid bacilli, and also to some other cages of sound animals. Soon after the presence of the ants was noticed, all the sound animals sickened with an epidemic of mouse typhoid. Plates of culture media over which the ants were allowed to run developed colonies of the mouse typhoid bacilli in a single straight line along the course of the ants, showing that the bacilli must have been retained as bees hold honey material, or else must have been passed in their dejecta. The colonies of other micro-organisms that developed on the plates were in parallel rows, corresponding to the ants' legs. Soon after these experiences Mayer himself developed an acute, brief but quite severe illness from infection with the mouse typhoid bacilli. The latter were found in his stools and urine, and the agglutination test was positive for the mouse typhoid bacilli at 1/250 during the second week. Severe pains in the epigastrium were a prominent feature of the illness, with diarrhea, chills, slight temperature and great depression. He was able to be up and about in five days, but the pains did not entirely subside until the sixth week.—G. Mayer, *Munchener Med. Wochenschrift*, Munich.

#### INHERITANCE OF TUBERCULOSIS.

Bossi's article is a contribution from an obstetrician to our knowledge of tuberculosis. He examined large numbers of placenta and of fetuses from women with tuberculosis, supplementing his research by experimental work. He found that it was a very rare exception when the Koch bacillus was transmitted to the fetus from the parents during its intrauterine existence. The toxins of tuberculosis may be transmitted. They seem to accumulate in the placenta and to pass thence into the fetus. The toxins thus transmitted are responsible for the defective development and organic weakness noted in such children. They favor infection during early infancy.—L. M. Bossi, *Archiv of Gynäkologie*, Berlin.

#### OPIUM IN HEART DISEASE.

According to Musser, there are sound clinical reasons for the belief that opium is a tonic in cardiac debility. He says that in cases of weak



heart after exhausting disease, after prolonged mental and physical pain, and without organic lesion of valves or muscles, opium is of advantage. In cases of failing compensation, with the onset of stasis, the heart is supported, especially if the unfortunate possessor is an impressionable subject who frets and fumes because of the ordinary irritations of life. In the gradual engorgements from myocardial dilatation, in chronic parenchymatous nephritis, and in arteriosclerosis it is of value. If the patient is hypochondriacal or hypersensitive the second daily dose of opium invites sleep and induces a feeling of well-being. The dyspnoea of myocarditis is relieved or prevented by continuous small doses of morphine for a very long time. Musser has seen a form or stage of myocarditis with restlessness, Cheyne-Stokes breathing, dyspnoea and rapid pulse helped by continuous doses of opium. The tachycardia of Graves' disease is relieved and in three of his cases it appeared to contribute to the cure of the disease. In nervous and irritable patients opium is almost necessary to induce comfort.—J. H. Musser, *American Journal of Medical Sciences*, Phila., Jany., '06.

#### ARTERIOSCLEROSIS AS A GENERAL DISEASE.

Stengel says that three stages of the disease may be recognized: 1. A preliminary one difficult of recognition in its beginnings and confusing to the clinician in his first efforts to distinguish what part the etiologic factors have contributed to the symptom-complex and what part has resulted from the arterial disease itself. 2. A middle period, during which the arterial disease is easy to recognize, but in which secondary organic changes have a role of variable importance. 3. A final stage of failure of circulation, organic failure and terminal infection. In the more advanced stages of arteriosclerosis the disease may be classified under the following headings: 1. The thoracic (a) cardiac or disturbances incident on special involvement of the coronary arteries; (b) aortic, referring not merely to aneurism but also to a sclerotic and calcareous roughening without dilatation but causing embarrassment of cardiac action. 2. Abdominal (a) renal, manifesting itself in the symptoms of chronic interstitial nephritis; (b) intestinal as evidenced by atrophy of the mucous membrane, tendency to chronic colitis, etc.; (c) pancreatic, difficult of recognition, often, however, active in diabetes; (d) hepatic, occurring as cirrhosis; (e) cerebrospinal—most numerous and varied; and (f) arteriocapillary, manifested in moderate circulatory disturbances.

#### MATERIA MEDICA AND THERAPEUTICS.

J. L. NAPIER, M. D.

#### A RECENT INVESTIGATION IN REGARD TO THE VALUE OF MEAT EXTRACTS.

Thirty or more years ago "beef tea" was very frequently given to patients suffering from various maladies, with the idea that by so doing

they were provided with an adequate quantity, or nearly adequate quantity, of nourishment. By the time that this practice had become almost universal various investigators began to point out that beef extracts in general possessed very little nutritive value, and that beyond the action of the salts which they contained they exercised no beneficial influence upon the organism other than that which might be produced by many harmless hot drinks. Indeed, investigation went a step further than this and proved that certain of the extractives found in home-made or other, beef extracts threw upon the kidneys a strain in their elimination which when combined with the increased work of the kidney produced by disease was capable of producing a deleterious effect. We have noted with interest in the October issue of the *University of Pennsylvania Medical Bulletin* a contribution by Dr. John Marshall, the professor of chemistry in that institution, in which he gives us the result of the investigation which he has made upon the fat content of Liebig's extract and of Witte's peptone.

As a result of this investigation he reaches the conclusion that these preparations contain only the slightest quantity of "nourishing material." He also points out that although the principal commercial meat extracts bears the name of Liebig, he was not the originator of such extract nor did he claim to have originated it. He did, however, encourage the formation of a company to manufacture extract of beef in London, and permitted it to be sold under his name upon condition that the company should sell only the extract which had been examined by him or his delegate, Professor von Pettenkofer. Now that both of these chemists are dead we do not know whether other chemists of equal eminence examine the product. The important point to be borne in mind, however, seems to be that which we have already named, to-wit, that these extracts may be employed as stimulants to the stomach and as "comforting drinks" if taken in conjunction with other food, but that they should not be relied upon in the slightest degree for the purpose of maintaining nutrition. As Parmentier and Proust suggested, such beef extracts may be advisable as an invigorating material for wounded soldiers, but not as a concentrated foodstuff.—*Exchange*.

#### THE ACTION OF SILVER NITRATE ON THE GASTRIC JUICE.

From a series of experimental researches, A. A. Baibakon draws some practical conclusions regarding the administration of silver nitrate in gastric diseases. The most interesting effect of this remedy is the increase of total acidity and of HCl in the gastric secretion. Even in conditions of hyperacidity, this increase takes place. Hence, all diseases with hyperacidity contraindicate the use of silver nitrate. Such are, among others, Reichmann's disease (gastrosuccorria) and the round ulcer. In these conditions, the routine use of silver nitrate is a great mistake. On the other hand, in diminished acidity, silver nitrate is a valuable remedy, which also appears to have certain antiepileptic virtues. Furthermore, silver nitrate has a distinctly antifermentative action, and is, therefore, in-

dictated in excessive fermentation. Another desirable effect of the remedy is the accelerated passage of the food through the stomach, suggesting its administration in torpid conditions of the gastric musculature. As to dosage, the author has found that small quantities (0.002 thrice daily) often exercise a beneficial effect, rendering the employment of large doses (0.03 thrice daily) seldom necessary, and thus lessening the danger of argyria. The mode of action of silver nitrate on the stomach remains as yet obscure. Possibly it stimulates the glands directly, although it is not to be denied that the drug may be taken into the blood and may then act on the central or the peripheral nerve-endings of the gastric nerve. [L. J.]—*Exchange*.

#### AMOUNT OF UREA IN THE URINE IN VARIOUS FORMS OF NEPHRITIS.

J. Mendl made estimations of the urea in 13 cases of nephritis both acute and chronic. In acute nephritis he found a good prognosis to be associated with an undisturbed excretion of urea. The prognosis must be guarded in cases where the urea is markedly diminished from the start, and is absolutely unfavorable when the amount excreted falls below 10 gm. a day. Similar results were found in chronic nephritis. In cases where the daily excretion of urea is normal, a favorable prognosis may be given, as long as no complications arise from other organs, such as the heart. The prognosis is unfavorable when when the urea is constantly below normal, and is in direct proportion to the amount of diminution. When the urea remains at the same level for some time, a gradual diminution indicates an exacerbation for the inflammatory process. [B. K.]—*Exchange*.

#### THE ACTION OF STOMACH BITTERS.

The belief in bitter tonics as appetizers and digestants is very widespread among the laity and the profession. Older physicians used to prescribe them for all sorts of disorders, while at present the field of their use has been somewhat narrowed down to gastric diseases. N. D. Strajsko made a series of experiments on animals, in order to clear up certain vexed features of the controversy as to the exact action of the bitters. The practical conclusions reached by him are: (1) The bitter tonics should be given in small doses. Large quantities will often defeat the purpose, and if used for some time may lead to hyposecretion; (2) in prescribing bitters, the chief aim should be to act on the nerves of taste. Therefore, the use of pills and capsules is nonsensical in this connection; (3) the bitters should be taken 10 to 15 minutes before a meal.—*Exchange*.

#### HOT-AIR TREATMENT OF JOINTS.

W. R. Thomson says that in proper cases its action is rapid and certain. A case seen during the first three days of an attack of articular inflammation will almost invariably be cured in three bakings. A case seen after six weeks of various treatments may require fifteen or more bakings before recovery is in sight. The usual length of baking is an hour and the heat is as high as the patient can stand. During the baking the patient is given a full glass of water,

which is sipped slowly. This promotes free sweating. After baking he bathes the part in warm grain alcohol or spirits of camphor and dries it carefully. The best results are obtained if the limb is kept at absolute rest in the most comfortable position until the next baking. Several cases are reported briefly. [C. A. O.] *Exchange*.

## OBSTETRICS AND DISEASES OF CHILDREN.

LANE MULLALLY, M. D.

#### VALUE OF ERGOT IN OBSTETRICS.

E. P. Davis, B. C. Hirst, J. C. Cameron and others *Therapeutic Gazette*.

Davis uses ergot in the majority of his obstetrical cases, but thinks it should not be used when hemorrhage is excessive and heart weak. Davis gives strychnia with ergot as a stimulant to the uterine ganglia.

Hirst uses ergot in all cases of labor after delivery of the child, persistent vomiting or intense nausea alone contraindicating its use.

If an anesthetic has been given, as soon as the uterus is emptied he administers a deep hypodermic injection of ergot into the thigh.

In a case of twins he gives a dram of ergot by the mouth as soon as the first child is born, unless there is some indication that the birth of the second child will be difficult.

Cameron gives ergot in all cases of labor after the uterus has been emptied.

All assert that they have never seen any evil results from the use of ergot administered after labor is completed.

#### A FACTOR IN PERINEAL LACERATIONS.

Shippo (*Med. Record*) contends that just previous to the birth of the child when the head begins to press against the perineum, that the extreme efforts at expulsion by the mother is an important factor in perineal laceration. This is so because sufficient time is not given for softening and stretching of the tissues. For this reason he urges that the patient cease all efforts at expulsion at this time, and believes the perineum remains intact in proportion as the expulsive efforts are controlled.

#### DIPHThERIA ANTITOXIN EFFECTIVE IN SCARLATINA.

Lopez (*American Medicine*) asserts that curative doses of diphtheria antitoxin given early in scarlatina will cut short the attack and lessen the danger of complications.

He finds the serum acts well in all anginas by neutralizing the toxins, and that it can be used in almost unlimited doses without any risk or danger.

#### ETIOLOGY AND PREVENTIVE TREATMENT OF SCARLATINAL NEPHRITIS.

Lowenbury (*Jour. Am. Med. Ass.*, Feby. 17, '06,) says that increased toxicity and increased acidity of the urine are among the important factors in the causation of nephritis following scarlatina. That the poison of scarlet fever is



removed from the economy via the urine, and possesses a peculiarly irritant effect on the kidney.

That the relationship between the concentration of the urine and its acidity is a positive one and therefore is an important etiologic factor.

Constipation, dietary indiscretions and exposure to cold and changes of temperature, are also contributory agents.

In the preventive treatment Lowenbury recommends first a well ventilated room. Second: the best diet is milk modified to suit the age of child.

That milk should be the sole diet until the end of the desquamative period.

That if asked to designate any one single remedy which is of the greatest service in preventing scarlatinal nephritis he would unhesitatingly name *water*. He recommends its use by mouth, balneotherapy and by enteroclysis, a combination of all these methods giving the best results.

That the only drugs of any value in preventing renal complications are alkalis and laxatives. Lowenbury condemns the use of urinary antiseptics and recommends the administration of citrate or acetate of potassium. Also small doses of calomel every three or four days followed by broken doses of sulphate of magnesium.

## RHINOLOGY AND LARYNGOLOGY.

BY W. PEYRE PORCHER, M. D.

The surgery of the nose undoubtedly demands as much originality on the part of the surgeon, and as much resourcefulness to meet an emergency as any part of the anatomy. A case in point was recently very illustrative of this fact. A patient appeared claiming that his nose had grown together, which condition had gradually become worse for eight or nine years past. On examination a very large fibroid tumor was found presenting in the right anterior nostril, and on further examination another (?) tumor was found filling the entire posterior nasal space. With the author's modification of Sajous' anterior nasal snare a large piece of the tumor was removed through the vestibule. The choanae was found to be entirely occluded by what proved to be the other end of the tumor, but which was attached by the entire under surface to the floor of the nose. Therefore the tumor could only be removed through the posterior nasal space. With the author's self retaining palate retractor the soft palate was first firmly retracted and a Jarvis curved snare having been armed with a stout steel wire, the loop having been bent forwards so as to encircle the depending portion of the growth it was passed up behind the soft palate, and the loop was tightened until the nut would turn no more. With the aid of considerable force the tumor was then torn from its base. Leaving a raw surface of perhaps three inches in length and one and a half in width. Strange to relate in spite of the large denuded surface the hemorrhage was not

very great and so complete was the removal and so great was the relief to the patient that one would scarcely believe that such a tumor ever occupied that position were it not that the tumor was here to prove it.

### PHOTOPHOBIA: A NASAL REFLEX.

Spear cites a case from which he draws the inference, that when light causes sneezing there must be a degree of hypersensitiveness of the nasal membranes, and that when light causes one to blink or wrinkle one's forehead the nose is at fault rather than the eyes themselves. Certainly, the author adds, may individuals contract the palpebral fissures in order to obtain clearness of vision.—*Exchange*.

Nasal reflexes and their influence over the eyes and other organs are daily being developed and exploited more than formerly. The above slip shows only one of the most frequent evidences of it. In a patient recently under treatment when ever a probe was introduced into either nostril he would feel the congestion coming on in the eye on that side and would immediately exclaim: "Watch that eye," and the ecchemosis would immediately start to appear. This must necessarily have been a pure neurosis since there was nothing whatsoever introduced into the eye itself.

### SYPHILITIC EMPYEMA OF THE ACCESSORY SINUSES OF THE NOSE.

The diagnosis of syphilis of the accessory sinuses is extremely difficult unless the disease appears externally or the history is very clear. When tertiary disease appears in the nose or naso-pharynx which so frequently occurs there should never be the least hesitance about pronouncing a positive and immediate opinion. It not unfrequently occurs that patients and sometimes even physicians not wishing to commit themselves will endeavor to gloss over the condition and will allow that there is a doubt about it. This is unfair both to the physician and to the patient, and an unqualified verdict should be rendered even if it incurs the enmity of the unfortunate victim or his friends.

Abraham says that no syphilitic patient is free from the possibility of tertiary manifestation, in one form or another, even after a thorough course of antisyphilitic treatment, lasting two years or more; therefore, all such patients should be advised to consult their physicians every one to three years subsequent to their treatment. Syphilitic empyema of the sinus of Highmore can be easily diagnosed with the aspirating needle, especially devised by the author. The treatment of the accessory sinuses quickly responds to specific treatment, as the administration of iodides, and conservative surgery such as removal of necrosed bone and granulation tissue, with a nasal bone forceps, curettes, and snares.—*Exchange*.

### INTERNATIONAL LARYNGO-RHINOLOGICAL CONGRESS AS MEMORIAL TO TURCK AND CZERMAK.

The Vienna Laryngological Society ("Wiener laryngologische Gesellschaft") is sending out an appeal to all interested in laryngology and rhinology to unite in a worthy memorial to

Türk and Czermak on the fiftieth anniversary of their pioneer work in clinical laryngology and rhinology. It is proposed to have the jubilee celebration take the form of an international congress for these specialties, to be held at Vienna, April 21 to 25, 1908. The appeal is signed by the president of the society, Prof. O. Chiari, I, Bellariastrasse 12, Vienna, Austria, and the secretary, Prof. M. Grossman, IX, Garnisonsgasse 10. They request that each scientific society, especially those devoted to these specialties, will appoint some one of its members who will remain in constant correspondence with the president of the acting committee in reference to all matters concerning the congress. The invitation to laryngologists and rhinologists to take part in the congress is cordial and urgent. The favor of an early acceptance is requested.—*Exchange*.

## Ophthalmology and Otology.

EDWARD F. PARKER, M. D.

### THE MONKEY'S VISION.

Dr. Charles Zell, writing on the eyes of animals, in the *Illustrierte Zeitung* (Leipsic), says:

In Berlin Zoological Garden, recently, the keeper of the monkey-house called my attention to the fact that the monkeys perceive the smallest objects from the highest points of the cage, as indeed the sparrow on the roof also sees the grain of corn in the street. The sharp discernment possessed by monkeys may be seen from the following example: One day I was wondering to myself that Dora, a female chimpanzee, did not pay the least attention to the people in the room, but kept looking through the window into the street. On my asking what interested her so greatly out there, the keeper replied that heretofore the cart she saw had been drawn by a horse, but that for some time a donkey had been hitched to it. The monkey knew the horse quite well. The donkey, however, was unknown to her, and had to be studied.

Almost every African traveler agrees that monkeys recognize at a great distance a beast lying in wait, and by their clamor inform both the hunter and the rest of the game of the proximity of danger.—*Abstract Review of Reviews*, March, 1906.

### INHERITED AND ACQUIRED SYPHILIS IN THE SAME SUBJECT.

Bruns, Henry Dixon, New Orleans (*Ophthalmic Record*, September, 1905). The case of hereditary and acquired syphilis in the same subject occurred in a negro, aged 23. He presented the characteristic appearances of hereditary syphilis as described by Hutchinson. At the same time he had a papular syphilide of the forehead and forearms, with an acute iritis of each eye, with multiple foci of gummatous infiltration, many posterior synechia, and classical, parenchymatous punctate keratitis.—*Abstract Ophthalmology*, Jan., '06.

### VISUAL AND HEARING ACUITY.

Struycken (*Tydschr. V. Geneesk.*, Jan. 21, 1905), reminds us of the imperfections of our highest senses in perception of the outside world. The measurement of their properties with strict rules will remain the first information of their action for a somewhat rational knowledge.

The direction-differentiation power. The coarse work is done for the eye by its muscles and the retinal periphery, the finer work is done by the macula lutea, helped by very sensitive memory. This we usually call visual acuity, which is low (Snellen) for practical purposes. The ear here is far in arrears, 15° to 30° difference of angle are not recognized with certainty; local conditions and individual differences have great influence.

Determination of distance. The eye does it through accommodation and with the muscular-sense for the binocular vision. The ear performs this only in connection with the memory-image (which the eye possesses in a much higher degree) and through the feeling of the vibration, when the sound source nears the auricle.

The ear excels in one way the eye. If we look at the curves representing the vibrations even of simple sounds, then the eye is unable to analyze them, while this analyzing power is possessed in a high degree by the ear and is followed directly by ideas and memorial impressions.—*Abstract Ophthalmology*, Jan., '06.

### HYGIENE OF THE EYES.

Haab, O., Zuerich (*Schweiz. Pädagog. Zeitschrift*, 1905). This is a popular address, delivered by Haab as rector of the University of Zuerich, and sets forth general principles for preservation of normal sight. After preliminary remarks on the physical act of seeing, presbyopia, hypermetropia, myopia and the beneficial effect of fully correcting glasses, the prevention of blennorrhoea neonatorum and venereal diseases, scrophulosis, smallpox and injuries are very lucidly discussed.—*Abstract Ophthalmology*, Jan., '06.

### TRANSPLANTATION OF RABBIT'S EYE.

Improvements in Ocular Prothesis by the Transplantation of the Rabbit's Eye. Lagrange, Bordeaux (*Archives d'Ophthalmologie*, July, 1905). Lagrange purposes to implant the eye of a rabbit in the capsule of tenon after enucleation and proceeds as follows:

1. In enucleating the eye of the patient a thread is placed in each of the straight muscles to prevent their retraction and to have them in hand.

2. After enucleation there must be a complete arrest of hemorrhage by means of iced cloths, prolonged tamponing, etc., before inserting the rabbit's eye.

3. An eye of a small medium size from a young animal is chosen.

4. The eye is introduced into the capsule of tenon and the muscles are sutured in front of it in pairs with fine silk or catgut.

5. The conjunctiva is sutured above the muscles.

6. An occlusive dressing is applied and the sutures are allowed to remain in place for a week. In inserting the eye the cornea is placed backward—looking toward the optic nerve—as



the sclerotic resist the pressure of the threads better. The author claims to have obtained a good permanent stump for prosthesis in eight cases out of eleven.—Abstract *Ophthalmology*, Jan. '06.

### BOOK REVIEWS.

The Ophthalmoscope and How To Use It; with Colored Illustrations, Descriptions and Treatment of the Principal Diseases of the Fundus.—By James Thorington, A. M., M. D.

P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia, Pa.

As an aid to diagnosis the ophthalmoscope is often of the greatest value and in some cases it is indispensable. With the ophthalmoscope, disease of the brain, kidneys, blood, etc., may at times be detected before other symptoms enable the diagnosis to be made with any degree of certainty. The use of the instrument should, therefore, be familiar to the general practitioner as well as to the specialist, and it is the aim of this work to enable the student or physician to acquire a sufficient working knowledge without going too deeply or extensively into the intricacies of the subject. A description of the ophthalmoscope with the technic of its use is given in the first chapter. Then follows a brief discussion of optics, refraction, myopia, astigmatism, etc. The anatomy of the eye; the normal eye ground; structural changes in the cornea, aqueous humor, etc.; visual acuity, and perimetry; diseases of the retina, of the optic nerve, and of the choroid, are severally discussed.

The book contains numerous wood cuts and twelve colored plates. The latter, the author tells us, "were made by a noted artist and under the writer's personal supervision, from individual patients in his own practice." These plates, which are excellent, illustrate the normal fundus and conditions which are of greatest interest to the general practitioner, i. e., embolism of the central artery, albuminuric retinitis, diabetic retinitis, atrophy of the optic nerve and glaucoma. The book is well gotten up

and will doubtless be of great assistance to the busy practitioner.

Diseases of Metabolism and of the Blood, Animal Parasites, Toxicology.

Edited with annotations by Richard C. Cabot, M. D., assistant in clinical medicine, Harvard University Medical School.

D. Appleton & Co., publishers. Price, in cloth, \$5.00.

This work is the second of the series entitled Modern Clinical Medicine, being a translation of *Die Deutsche Kliniok*, edited under the supervision of Julius L. Salinger, M. D. The names of the contributors to this volume are guarantee of its great worth, e. g., C. v. Noorden, B. Naunyn, W. Ebstein, P. Ehrlich, W. von Leube, H. Senator, R. v. Jaksch, etc.

The book opens with a discussion of the Consumption of Food in the Healthy and the Food Requirement of the Sick. The author of this chapter, Weintraud, does not accept the sufficiency of the *dynamic* point of view but approves of Hoppe-Seyler's assertion that "the process of life in the organism is, in the main, a complete mystery," and says that "the investigator gets his inspiration not from the hope of a speedy solution of the problem, but purely in the exhilaration of steady work and steady progress upon the path already trodden; still the goal itself must never be lost sight of." Over-nutrition and Under-nutrition are treated by C. v. Noorden. Then are discussed the diseases of metabolism: Diabetes Mellitus, Diabetes Insipidus, Gout, Obesity, Myxedema, Addison's Disease, Acromegateia, Chronic Articular Rheumatism, and Pentasuria. The subject of Blood and Blood Examination is then considered very fully, after which follow: The Anemias, Chlorosis, Leukemia, Pseudo-Leukemia, The Hemorrhagic Diathesis, Hemophilia, and Purpura. The concluding sections treat of The Animal Parasites of Man, and Important Poisons and Their Treatment. There is probably no book in the English language in which the obscure subject of

metabolism and its perversions is treated so clearly and scientifically, and those who do not read German are greatly indebted to the translator and editors for making this work available. The second volume of the series maintains the high standard of the first and will doubtless take a foremost place as the latest authoritative utterance upon the subject treated.

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"Diseases of Infancy and Childhood," for the use of Students and Practitioners of Medicine.—By L. Emmett Holt, M. D., Sc. D. L. L. D., Professor of Diseases of Children in the College of Physicians and Surgeons, (Columbia University) New York: Attending Physician to the Babies and Foundling Hospitals, New York; consulting Physician to the New York Infant Asylum, Lying in Hospital, Orthopedic, and Hospital for the ruptured and crippled.

With two hundred and forty-one illustrations, including eight colored plates. Third edition, revised and enlarged.

Price, in cloth, \$6.00. D. Appleton & Co., New York, publishers.

This work is divided by the author into two parts: the first of which includes chapters on Hygiene, and the general care of infants and young children. The growth and development of the baby. Peculiarities of diseases in children.

In speaking of the use of anti-pyretic drugs, the author gives definite indication for the use of phenacetine, and explains the use of this drug to reduce temperature in certain cases. The paragraph relative to the use of stimulants is timely and appropriate.

Part two commences with a section on diseases of the New Born, and concludes with one on such general disorders as rheumatism, diabetes, etc.

One of the strongest points in this work is the completeness with which the section on nutrition is written. Complete formulae and directions relative to the preparations of milk are therein dis-

cussed, which places before the profession in a practical way this most important subject of paediatrics; without a thorough mastery of which, no physician can hope to combat the various disorders of infancy and childhood.

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The World's Anatomists.—By G. W. H. Kemper, M. D., with eleven illustrations, nine of which are portraits.

P. Blakiston's Son & Company, publishers.

This is a revised edition in which sixty-one additional names have been added to the previous work, which contained one hundred and sixty-eight names. Besides this change, the names of sixteen authors of works on anatomy have been appended. Short sketches of the prominent anatomists are given, and the work is illustrated with nine portraits.

It is a small book, but contains much information for those interested in medical history.

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Lectures on Tropical Diseases.—Being the Lane Lectures for 1905, Delivered at Cooper Medical College, San Francisco, U. S. A. By Sir Patrick Manson.

W. T. Keener & Co., Chicago, publishers.

In these lectures the author discusses the more common tropical and subtropical diseases of which he has not only a thorough scientific knowledge but also a most wide-ranging practical experience.

Beginning with the principles determining the geographical distribution of tropical diseases and calling attention to the fact that many of these diseases will probably be introduced into our midst by the ever increasing channels of commerce with tropical countries, he goes into detail regarding the etiology, modes of transmission, symptoms, diagnosis, prophylaxis and treatment of the more common of these affections. The concluding lecture is on the problems in tropical medicine in which he calls attention to the responsibilities resting upon in-



dividuals and governments to observe the strictest quarantine in opening up new and quicker lines of travel with the tropics, lest we have not only an interchange of trade but an introduction of diseases now foreign to each shore.

The author also advises the establishment of, and lays down rules for the guidance of schools of tropical medicine where familiarity with these diseases may be acquired.

While there is nothing new in the series of lectures, yet the book is so charmingly written and the reading so delightfully easy and interesting that one cannot but be impressed and benefitted by its perusal.

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#### MISCELLANY.

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##### THE TRI-STATE MEDICAL ASSOCIATION.

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The 8th Annual Session of The Tri-State Medical Association of the Carolinas and Va. met at White Stone Lithia Springs, S. C., Feb. 27 and 28, 1906. There were present 275 members. An interesting program was presented—made especially attractive by addresses from Drs. Jos. Price, Alfred Strengel, John B. Deaver, Merrill Picketts and W. D. Haggard. About 35 new men were added at this meeting and Norfolk, Va., selected as next place of meeting in 1907. "Surgery of the Stomach" will be the special subject for discussion at next meeting, with Dr. Stuart McGuire, of Richmond, Va., Dr. H. A. Royster, of Raleigh, N. C., and Dr. LeGrand Guerry, of Columbia, S. C., as leaders of debate.

Officers for ensuing year: Prest., Dr. Ralfe E. Hughes, of Laurens, S. C., V.-P. N. C., Dr. I. M. Taylor, Morgantown, N. C.; V.-P. S. C., Dr. J. A. Hayne, Greenville, S. C.; V.-P. Va., Dr. W. E. Driver, Norfolk, Va.; Executive Council vacancies filled by Dr. C. B. Earle, of Greenville; Dr. Benj. K. Hays, of Oxford, N. C.; Dr. J. S. Haisley, Richmond, Va. Magnificent banquet served by Springs Co. night of 27th.

#### THE DESTRUCTION OF FLIES.

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The fly is doomed; the fiat has gone forth, and its days are numbered. Doctors have recognized the fact that the house fly is not only a nuisance, but also a real danger, because it is the bearer of microbes and nastiness of all kinds. Fired with the spirit of enterprise, and wishing to do good to humanity at large, the *Matin*, of Paris, recently offered a prize to the discoverer of the most practical and efficacious means of destroying these insect pests, and thus eliminating one great source of the spread of epidemics.

A pamphlet entitled "Delenda Musca" has carried off the prize.

According to the writer of this essay, very few people are aware that the domestic fly lays its eggs in cesspools, drains, liquid manure, and dung heaps of all kinds. In these delectable media the *Musca domestica* deposits oblong eggs, which are opened by the detachment of a narrow longitudinal band or strip—much in the same way as the blade of a knife is opened. The larvæ grow with surprising rapidity, attaining their full size, in summer, in eight days' time. One fly may give birth to millions of others, as it breeds continuously for several consecutive months (usually from May to October). Assuming that one specimen lays 200 eggs (containing an equal number of males and females) then, as will be seen from an easy calculation, in six months' time one hundred thousand million flies will be brought into the world to tease bald-headed men and the helpless in general. After showing that it is useless to attack the full-grown insect, the author seeks some means of destroying it while it is in the period covered by the laying of the egg to the formation of the pupa—just when the insect is most vulnerable, and is found collected together in more or less considerable quantities. The greatest points of attention to this end are cesspools, muck heaps, drains, manure heaps, and the like. Arsenic and arsenical compounds should not be used

for the destruction of flies' eggs and larvæ in open cesspools in country districts, where—too often, unfortunately—they are in underground or other communication with wells, watercourses, and springs, which might thus get poisoned. Recourse should be taken to some substance which not only dissolves in the liquid contained in the drain, but which will penetrate right into the heart of solid matter. This substance must be of a nature to withstand fermentations and all transformations experienced by the solids contained in the cesspool, as they are always, in such media, of ammoniacal and reductive nature. These reactions show that it is useless to employ sulphate of iron, sulphate of copper, etc., for although in the beginning these metallic salts might have some effect, they would subsequently become changed by fermentative influences and lose their efficacy. The first trials made showed that ordinary soda, mixed with ordinary chloride of zinc (in the proportion of 5 kilogrammes of each to every cubic meter of matter), was quite sufficient to kill the larvæ and prevent the hatching of further eggs laid in the same place during the season. This process could, if necessary, be used for stationary, hermetically closed cesspools, but it would not do for movable closets, sewage tanks, or open drains. Petroleum was then tried by the author of the pamphlet in question, in the proportion of one liter to every superficial meter; but in a short space of time—due probably to the slight rise in temperature caused by fermentative processes—the petroleum disappeared. This was verified by putting a stick into the cesspool; if petroleum had still been present, it would have left traces thereon. Coal tar was then tried with much better results, although they were still not all that could be desired. The most satisfactory results were secured with raw petroleum or raw schist oil (residue of distillation). Two liters per superficial meter were mixed with water, the whole being well stirred up with a piece of wood. This, on being poured into a drain or closet, will form a stratum of oil which

will destroy all the larvæ, while, even should flies not be prevented from entering the drain, at least all the eggs they may deposit will be prevented from hatching. This oil is sufficiently consistent and tenacious to adhere to the walls of drains, to form a coating over solids, and remain attached thereto for a long time. This protective layer of oil also facilitates the development of anærobic bacteria which cause the rapid liquefaction of solids, thus rendering them quite unsuitable as a breeding ground for Diptera. In the case of manure heaps this oil may be mixed with earth, lime, and fossil phosphates, in which state it is sprinkled (preferably in the spring) over all sources likely to tempt young couples of the Diptera family to start housekeeping and the rearing of a family.—*Scientific American*.

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#### STAMPING OUT YELLOW FEVER AND MALARIA AT PANAMA.

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Thanks to the splendid work of Col. W. C. Gorgas, U. S. A., the chief sanitary officer of the canal zone, it has already been proved that yellow fever and malaria, the two prevailing diseases, can be successfully combated and practically stamped out. Yellow fever is conveyed from man to man only by the female *Stegomyia*, who must have previously bitten some human being suffering from yellow fever. Therefore, yellow fever cannot originate in a place where there are no infected *Stegomyia*, until a yellow fever patient has been introduced and has infected the local pest; or until the mosquito, infected at some distant point, has been introduced. Practically, the introduction of a yellow fever patient is the only method by which the locality can be infected.

The immediate object of the sanitary measures is to get rid of all infected *Stegomyia*. This can be accomplished with great certainty by establishing a system whereby the health authorities are certain to be informed of every case of yellow fever; and then fumigating the house in



which this case occurred, so as to destroy all the mosquitoes within its borders. The same thing must be done with all contiguous houses. It has been found by experience that this kills all the infected mosquitoes at that particular focus. By doing the same thing at every other focus as yellow fever occurs, all the foci in the community are gradually destroyed, and when the last focus has been got rid of, yellow fever is at an end. A more expeditious method is to systematically fumigate every house in the town.

The *Stegomyia* is a house mosquito, and being cleanly in her habits seeks principally the clean-water barrels and water containers, and never travels far from her birthplace. Therefore, as an additional sanitary safeguard, every receptacle for water should be so screened that mosquitoes cannot have access to it. The safest precaution is to pipe the water supply in from a distance, so that the people will not need to keep a supply of water in vessels.

How well the government has succeeded in stamping out yellow fever, is proved by the statement of Governor Magoon, made during his recent testimony at the Senate investigation at Washington, that January 26, 1906, was the seventy-fourth day since there had been a case of yellow fever at Panama, and the ninetieth day since there had been a clearly established case at Colon.

An even more important problem than that presented by yellow fever is the control of malaria throughout the Canal Zone. The ten thousand natives of the district are distributed in about twenty small villages along the route of the canal, and these people are very generally affected with malaria. A microscopic examination of the blood of these people, taken at random at various points along the line, showed that out of several hundred cases, fifty per cent. contained mosquito parasites in the blood. Four times out of five, if the female *Anopheles* bites a native she becomes infected, and when she bites one of our nearby laborers, he in turn becomes infected. Hence, if our laboring force is not to be completely used

up as was that of the French government, preventive sanitary measures must be taken.

There are two ways of approaching this problem; either by doing away with the infected human being, or by doing away with the mosquito. Since it is out of the question to do away with the infected natives, the remedy must be sought in the extinction of the mosquito. If some substance could be introduced into the circulation of the infected man and kill the parasite, and at the same time not be injurious to the man, the desired object would be effected, and in quinine has been discovered the suitable poison. This vegetable substance is harmless to man and fatal to the malarial parasite. Most of the effective sanitarians, the Germans and the Italian conspicuously, have achieved a great success by inducing as large a proportion of the population as possible to take regularly small quantities of quinine, and they have succeeded, without adopting any other measures, in doing away with malaria in the several localities.

The disease may also be successfully attacked from the side of the mosquito, and the *Anopheles* may be as effectively exterminated as the *Stegomyia* by covering up water containers, clearing up the yards, preserving the surface of the roads so there will be no puddles, instituting a regular system in all towns for the collection of garbage, and by the use of oil. Asked in regard to the prevalence of malaria, Governor Magoon stated that the percentage of malaria on the Canal Zone to-day is no greater than it was in any of our frontier States while they were new countries in process of being settled. Col. Gorgas confidently expects to get malaria as completely under control as yellow fever is now known to be—*Scientific American*.

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#### CAUSE OF OVERHEATING HOUSES.

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Dr. Henry Mitchell Smith, of Brooklyn, in a paper read before the Brooklyn Medical Society, says: The neglect of the

element of watery vapor in the air is the greatest cause of overheating our houses. A low humidity is the great cause of discomfort, the source of much ill-health, catarrhs, colds and other diseases of the mucous membranes, skin, etc. Experience and special tests show that we are perfectly comfortable in a temperature of sixty-five to sixty-eight degrees if the relative humidity is fifty per cent. to sixty-five per cent. If the relative humidity falls below fifty per cent. we get cold and chilly at sixty-five to sixty-eight degrees, and call for more heat, and we are not satisfied with a temperature below seventy to seventy-two. The fact that we are uncomfortable at sixty-five to sixty-eight proves there is insufficient moisture in the atmosphere of the room or that we are below par in health. If the latter is the trouble we will know it by slight fever, lassitude, a tired feeling, headache, etc.

Not only does indoor humidity affect the health unfavorably if deficient, but the pocket-book is also unfavorably affected. This plainly appears when we learn that about twenty-five per cent. of the cost of heating occurs in raising the room temperature from sixty to seventy degrees, so if we can keep comfortable at a temperature of sixty-five degrees we shall have saved at least twelve and one-half per cent. of the total cost of heating. A further health consideration, depending upon moisture in the air, lies in the fact that living in an atmosphere of less than fifty per cent. humidity the mucous surfaces are sure to lose moisture and invasion of infection is invited.—*Journal of the Outdoor Life.*

#### NOTICES OF THE APPROACHING ANNUAL MEETING.

The 58th Annual Meeting of the Association will be held in Columbia, April 18th, 19th, (and if necessary 20th), 1906.

The Secretary begs to issue this the second call for the titles of papers to be presented at the meeting. Papers appearing upon the program will have precedence

over those offered at the meeting.

It was the intention of the Secretary to publish a preliminary program in this issue of the journal; but inasmuch as so few titles have thus far been sent he has abandoned this idea; and begs to announce that he will issue a provisional program which will be sent to each member of the Association between April 1st and 5th.

The Secretary would suggest that members having acquaintances in the profession, who are not members of the Association but who desire to attend, invite such acquaintances to the meeting, where in all probability they will be granted the privileges of the floor during the scientific session.

The Secretary would call the attention of the Secretaries of the County Societies to the fact that the House of Delegates will convene at 2:00 P. M. on the day before the first meeting of the Association, that is on April 17th. He would also request that the delegates post themselves on the constitution, this will greatly facilitate the business to be transacted by the House of Delegates.

The annual address will be delivered by Dr. Paul B. Barringer of the University of Virginia, entitled "The Drugs That Enslave." A special paper will also be read by Dr. Wm. T. English of Pittsburg, an honorary member of the Association, entitled, "Subsidiary Contributions to Medical Success."

Further information concerning the meeting will be furnished by the Secretary upon application at any time; and additional information will appear upon the preliminary program.

#### AFFILIATED COUNTY SOCIETIES WITH MEMBERS.

##### ABBEVILLE.

(ABBEVILLE COUNTY MEDICAL SOCIETY.)

Secretary, C. C. Gambrell, Abbeville.

J. A. Anderson.....	Autreville.
J. R. Bell.....	Due West.
P. R. Black.....	Mt. Carmel.
J. B. Britt.....	Troy.
J. M. Carlton.....	Mt. Carmel.
C. C. Gambrell.....	Abbeville.



F. E. Harrison.....	Abbeville.
L. T. Hill.....	Abbeville.
J. W. Keller.....	Abbeville.
T. O. Kirkpatrick.....	Lowndesville.
D. S. Knox.....	Autreville.
Frank Lander.....	Williamston.
S. Mare.....	Anderson.
G. A. Neuffer.....	Abbeville.
W. H. Pepper.....	Anderson, R. F. D
J. M. Richardson.....	Anderson.
M. W. Strickland.....	Pelzer.
J. W. Wideman.....	Due West.
J. D. Wilson.....	Lowndesville
W. W. Wilson.....	Williamston.

## ANDERSON.

(ANDERSON COUNTY MEDICAL ASSOCIATION.)

*Secretary, J. B. Townsend, Anderson.*

Frank Ashmore.....	Anderson.
R. B. Day.....	Pendleton.
W. R. Dendy.....	Pelzer.
J. L. Gray.....	Anderson.
J. C. Harris.....	Anderson.
W. R. Haynie.....	Belton.
B. A. Henry.....	Anderson.
W. S. Hutcherson.....	Anderson, R.F.D.
W. H. Nardin.....	Anderson.
W. H. Nardin, Jr.....	Anderson.
R. P. Ransom.....	Williamston.
J. B. Townsend.....	Anderson.
W. W. Watkins.....	Pendleton.
R. G. Witherspoon.....	Anderson.

## AIKEN.

(AIKEN COUNTY MEDICAL SOCIETY.)

*Secretary, W. C. R. Turnbull, Aiken.*

T. G. Croft.....	Aiken.
B. S. Dunn.....	Aiken.
T. P. Edwards.....	Graniteville.
L. B. Etheridge.....	Wagner.
W. S. Eubanks.....	Talatha.
J. I. Green.....	Bath.
T. Hall.....	Aiken.
M. M. Lecroy.....	Langley.
W. E. Mealing.....	North Augusta.
C. F. McGahan.....	Aiken.
J. A. Millhouse.....	Perry.
V. Mott.....	Aiken.
H. J. Salley.....	Salley.
W. H. Shaw.....	Langley.
C. A. Teague.....	Graniteville.
W. C. R. Turnbull.....	Aiken.
J. R. A. Whitlock.....	Kitchen's Mill.
W. A. Whitlock.....	Kitchen's Mill.
W. D. Wright.....	Langley.
B. F. Wyman.....	Aiken.
J. F. Wyman.....	Aiken.
H. H. Wyman, Sr.....	Aiken.
H. Hastings Wyman, Jr.....	Aiken.
Harry H. Wyman.....	Aiken.

## BARNWELL.

(BARNWELL COUNTY MEDICAL SOCIETY.)

*Secretary, L. F. Bonner, Blackville.*

L. F. Bonner.....	Blackville.
D. K. Briggs.....	Blackville.
S. R. Hickson.....	Kline.
R. C. Kirkland.....	Barnwell.
J. A. McCreary.....	Williston.
E. L. Patterson.....	Barnwell.
W. C. Smith.....	Williston.

## CHARLESTON.

(MEDICAL SOCIETY OF SOUTH CAROLINA.)

*Secretary, J. C. Mitchell, Charleston.*

C. P. Aimar.....	Charleston.
R. Alston.....	Charleston.
A. E. Baker.....	Charleston.
J. A. Ball.....	Charleston.
L. D. Barbot.....	Charleston.
R. L. Brodie, Hon.,	Charleston.
A. J. Buist.....	Charleston.
J. S. Buist.....	Charleston.
J. W. Burn.....	Charleston.
R. S. Cathcart.....	Charleston.
W. P. Cornell.....	Charleston.
J. L. Dawson.....	Charleston.
H. W. DeSaussure.....	Charleston.
— Fishburne.....	Pinopolis.
J. Frampton.....	Mt. Pleasant.
F. L. Frost.....	Charleston.
Jno. Forrest.....	Charleston.
J. P. Galvin.....	Charleston.
J. M. Green.....	Charleston.
A. H. Hayden.....	Summerville.
W. H. Huger, Hon.	Charleston.
B. W. Hunter.....	Charleston.
H. P. Jackson.....	Charleston.
J. A. Jervy.....	Charleston.
F. B. Johnson.....	Charleston.
W. H. Johnson.....	Charleston.
R. S. Kirk.....	Charleston.
C. W. Kollock.....	Charleston.
Jos. Maybank.....	Charleston.
Wm. Mazyck.....	Charleston.
A. Memminger.....	Charleston.
J. C. Mitchell.....	Charleston.
G. McF. Mood.....	Charleston.
Lane Mullally.....	Charleston.
E. F. Parker.....	Charleston.
F. L. Parker, Hon.,	Charleston.
W. P. Porcher.....	Charleston.
C. M. Rees.....	Charleston.
Edw. Rutledge.....	Charleston.
T. M. Scharlock.....	Charleston.
C. H. Schroeder.....	Charleston.
Manning Simons, Hon.,	Charleston.
T. G. Simons, Hon.,	Charleston.
J. C. Sosnowski.....	Charleston.
A. R. Taft.....	Charleston.
J. S. Taylor.....	Charleston.
T. P. Whaley.....	Charleston.
G. F. Wilson.....	Charleston.
J. LaR. Wilson.....	Charleston.
Robt. Wilson.....	Charleston.

## CHEROKEE.

(CHEROKEE COUNTY MEDICAL SOCIETY.)

*Secretary, B. L. Allen, Gaffney.*

B. L. Allen.....	Gaffney.
W. Anderson.....	Blacksburg.
B. R. Brown.....	Gaffney.
I. B. Crawley.....	Gaffney.
J. T. Darwin.....	Gaffney.
S. H. Griffith.....	Gaffney.
C. A. Jeffries.....	Gaffney.
C. M. Littlejohn.....	Gaffney.
R. F. McKown.....	Cherokee Falls.
I. N. Nesbit.....	Gaffney.
W. L. Littlemeyer.....	Gaffney.
M. W. Smith.....	Gaffney.
B. B. Steedly.....	Gaffney.

## CHESTER.

(CHESTER COUNTY MEDICAL SOCIETY.)

*Secretary, W. B. Cox, Chester.*

A. F. Anderson.....	Laceysville.
J. M. Brice.....	Chester.
W. B. Cox.....	Chester.
F. M. Durham.....	Blackstock.
R. L. Douglas.....	Rodman.
J. G. Johnson.....	Chester.
G. W. Jordan.....	Chester.
T. B. Kell.....	Catawba.
H. E. McConnell.....	Chester.
C. B. McKeown.....	Fort Lawn.
S. G. Miller.....	Chester.
S. W. Pryor.....	Chester.
W. DeK. Wylie.....	Richburg.
A. M. Wylie.....	Chester.
J. P. Young.....	Richburg

## CLARENDON.

(CLARENDON COUNTY MEDICAL SOCIETY.)

*Secretary, L. C. Stukes, Summerton.*

J. T. Davis.....	Summerton.
C. B. Geiger.....	Manning.
W. R. Mood.....	Summerton.
M. D. Murray.....	Pinewood.
L. C. Stukes.....	Summerton.
H. S. Wilson.....	Jordan.
Heyward Wood.....	Turbeville.
I. M. Wood.....	Sardinia.

## COLLETON.

(COLLETON COUNTY MEDICAL SOCIETY.)

*Secretary, C. H. Es Dorn, Walterboro.*

Riddick Ackerman.....	Walterboro.
W. B. Ackerman.....	Walterboro.
C. H. Es Dorn.....	Walterboro.
T. G. Kershaw.....	Youngs Island.
W. A. Kirby.....	Cottageville.
J. B. Padgett.....	Getsinger.
B. G. Willis.....	Hendersonville.
J. T. Taylor.....	Adams Run.

## DORCHESTER.

(DORCHESTER COUNTY MEDICAL ASSOCIATION.)

*Secretary, J. B. Johnston, St. George's.*

W. M. Carn.....	St. George.
J. T. Carter.....	Branchville.
J. D. Conner.....	St. George.
A. H. Hayden.....	Summerville.
P. L. Horn.....	St. George.
A. R. Johnston.....	Reevesville.
J. P. Johnston.....	St. George.
P. M. Judy.....	St. George.
H. B. Lee.....	Summerville.
J. P. Mellard.....	St. George.
E. D. Tupper.....	Summerville.
W. B. Way.....	Ridgeville.
J. S. Wimberly.....	Branchville.

## FLORENCE.

(FLORENCE COUNTY MEDICAL SOCIETY.)

*Secretary, Wm. Ilderton, Florence.*

A. G. Eaddy.....	Florence.
N. W. Hicks.....	Florence.
Wm. Ilderton.....	Florence.

T. C. Johnson.....	Mars Bluff.
J. D. Lewellen.....	Friendfield.
F. H. McLeod.....	Florence.
W. E. Mills.....	Timmons-ville.
O. C. Odell.....	Friendfield.
R. H. Pearce.....	Clausens.
J. H. Pearce.....	Cartersville.
W. L. Whitehead.....	Timmons-ville.
M. B. Young.....	Georgetown.

## GEORGETOWN.

(GEORGETOWN COUNTY MEDICAL SOCIETY.)

*Secretary, W. M. Gaillard, Georgetown.*

C. W. Bailey.....	Georgetown.
H. D. Beckman.....	Georgetown.
J. W. Folk.....	South Island.
W. M. Gaillard.....	Georgetown.
Covington Lee.....	Harpers.
M. P. Mooror.....	Georgetown.
W. D. Simpson.....	Georgetown.
O. Sawyer.....	Georgetown.
W. E. Sparkman.....	Georgetown.
W. B. Young.....	Georgetown.

## GREENVILLE.

(GREENVILLE COUNTY MEDICAL SOCIETY.)

*Secretary, J. A. Hayne, Greenville.*

T. W. Bailey.....	Greenville.
W. C. Black.....	Greenville.
G. H. Bottum.....	Greenville.
E. W. Carpenter.....	Greenville.
L. G. Corbett.....	Greenville.
C. B. Earle.....	Greenville.
J. B. Earle.....	Greenville.
T. T. Earle.....	Greenville.
Davis Furman.....	Greenville.
C. T. J. Giles.....	Greenville.
B. F. Goodlett.....	Travelers Rest.
J. A. Hayne.....	Greenville.
E. B. Hendrix.....	Reedy River.
R. E. Houston.....	Greenville.
F. G. James.....	Greer.
J. W. Jervey.....	Greenville.
C. C. Jones.....	Greenville.
W. L. Marchant.....	Geers.
G. L. Martin.....	Greenville.
W. Y. McDaniel.....	Taylor.
J. E. McKinney.....	Greenville.
W. L. Mauldin, Jr.....	Greenville.
W. S. Pack.....	Greenville.
L. L. Richardson.....	Simpsonville.
H. L. Shaw.....	Fountain Inn.
R. D. Smith.....	Greenville.
L. C. Stevens.....	Greenville.
G. T. Swandale.....	Greenville.
J. R. Ware.....	Greenville.
A. Wallace.....	Greenville.
C. O. West.....	Greenville.
A. White.....	Mauldins.
W. E. Wright.....	Greenville.

## GREENWOOD.

(GREENWOOD COUNTY MEDICAL SOCIETY.)

*(Secretary, J. B. Huger, Greenwood.)*

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W. G. Stevens.....	Rock Hill.
M. J. Walker.....	Yorkville.
T. S. R. Ward.....	Hickory Grove.
W. G. White.....	Yorkville.

## HONORARY FELLOWS.

1870.....	F. L. Parker.....	Charleston.
1871.....	T. G. Simons.....	Charleston.
1872.....	J. C. Spann.....	Catchall.
1873.....	A. A. Moore.....	Camden.
1873.....	M. G. Salley.....	Pinewood.
1873.....	R. L. Brodie.....	Charleston.
1874.....	W. H. Nardin.....	Anderson.
1874.....	J. F. Pearce.....	Claussens.
1874.....	O. B. Mayer.....	Newberry.
1875.....	T. G. Croft.....	Aiken.
1875.....	Manning Simons .....	Charleston.

The following Counties have not yet affiliated:

Bamberg.	Darlington.
Beaufort.	Edgefield.
Berkelev.	Lancaster.
Chesterfield.	Orangeburg.
Clarendon.	

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### South Carolina Medical Association.

Next Annual Meeting at Columbia, S. C.,  
April 18th, 1906.

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THE JOURNAL is published monthly under the auspices of the South Carolina Medical Association. Members who do not receive their copies will please notify the Managing Editor at once. Secretaries of county societies are requested to send reports of their meetings, and items of news that may be of interest to the profession. Original articles are solicited. Articles should be type-written; and illustrations sent with articles will be printed at the expense of the writer. Reprints will be furnished at the rate of 75c. a page for a hundred copies.

All matter must be in the hands of the editor by the 10th of each month.

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## EDITORIAL COMMENT.

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### SIDE ISSUES.

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There is no profession whose pursuit is so filled with exacting duties and corroding anxieties as that of medicine. Physicians, therefore, by reason of the great sacrifices of body and mind which their calling entails, need refreshment and recreation even more urgently than worn doctor some kind of diversion is other men. To the body-weary and care-essential to the just fulfilment of his daily task, and is a duty owed not only to himself and his family but to his patients also. Some of us steal away now and then for a day's hunting or fishing, and others take a summer vacation of two or three weeks, but few of us understand the art of finding refreshment in the midst of daily toil, and yet to him who has the key it is an easy thing to do. The most refreshing rest is not idleness, but

change of occupation, and none of us should allow himself to be so busy that a few moments cannot be spared for the prosecution of some favored study. Literature supplies an inexhaustible field for the pleasantest diversion, and a few minutes' daily communion with some congenial spirit of an older time can always be secured. Perhaps it might be best to pursue some specific line of study instead of wandering aimlessly, but there are times when the latter course possesses a peculiar charm. Physicians who never stray beyond the narrow limits of professional study can form no conception of the delightful sense of power and dominion and the complete independence of time and place imparted by general reading.

"I am master of the sphere,  
Of the seven stars and the solar year,  
Of Caesar's hand, of Plato's brain,  
Of Lord Christ's heart and Shakespeare's strain."

Parson Adams owned no worldly goods and was a mere infant in the ordinary affairs of life, but he could say to his host, and truly, too: "I can travel farther in an afternoon than you in a twelvemonth." Perhaps many will find the pursuit of some scientific study more congenial occupation. If so, botany and astronomy and geology are within the reach of all. A country road can never be lonely while flowers bloom and the stars shine, and meadow streams carve the land and polish the stones. In the smallest back yard the abundant variety of insect forms will supply material to fill with entertainment and profit the leisure moments of a lifetime. The study of man himself in all the many phases of his development may appeal more strongly to others and herein will be found many things that will be useful to us in our technical labors.

And let us not forget another field for recreative work which we all should cultivate, not as a side issue only, but because it contributes so directly to the making of the full and rounded physician—medical history. There are mines of treasure here whose exploration is sure to reward us with profit as well as pleasure. We may gather much to in-



spire us even in our own neglected local field. How many of us remember Lining, whose experiments gave him international fame? Or Alexander Garden, "*facile princeps* among his colleagues," and probably better known outside of the medical profession than within it? Or J. Lawrence Smith, who was elected to succeed Sir Charles Lyell to the Institute of France, "the highest honor within the gift of the scientific world"?

These are only a few of the pursuits which physicians might cultivate as side issues to give rest to weary limbs and refreshment to jaded minds, as well as teach lessons which can never be learned in the daily hurly-burly. Our fathers appreciated the value of side issues, and if we would make an effort to follow in their worthy steps we would not only add bright hours to dreary days, but would bring around once more a generation of cultured men to uphold the best traditions of our past.

#### Church Temperance Societies on Patent Medicines.

A great deal of harm is often done by members of the clerical profession who, thoughtlessly no doubt, allow their names and photographs to be used for the purpose of advertising patent medicines. Many of these good men would doubtless be shocked if they realized that the preparations which they innocently advised people to drink depend for what little virtue they may possess upon alcohol, which is present, in most cases, in such amounts as to place the user in jeopardy of contracting the alcohol habit. We are glad to note that the special committee of the Church Temperance Society appointed to consider this question has recommended that decided action be taken, and we hope the influence of all the churches will soon be exerted in behalf of the good cause. The report, which we quote in full speaks for itself.

"The Special Committee of the Church Temperance Society, appointed at the meeting held Feb. 13th, 1906, to consider the subject of the promotion of intemperance by the extensive advertisement and general use of those proprietary medicines, the analysis of which has shown that they are largely composed of alcohol, cocaine,

morphine, or other like ingredients that are notably injurious, respectfully report:

"1. Our investigations have made us certain that scientific and expert chemists are quite sufficient authority for our Church Temperance Society to state that certain well-known preparations for the cure of colds and catarrh, and the tonics for depleted systems, are deleterious to health, and distinctly encouraging the habits of intemperance.

"2. It is of painful interest and anxious concern to those who represent a Church Temperance Society to observe that a reliable secular magazine has been outspoken in its condemnation of the extremely immoral attitude of the religious press in general toward this subject, and also of the lazy habit of clergymen throughout the country in giving testimonials to any kind of patent medicine, when they are wholly ignorant, or are supposed to be, of the composition of such medicines.

"3. It is especially gratifying to observe that the clergy of the Episcopal Church are generally free from the stigma of the charge of giving personal recommendations to proprietary medicines, and also that in the condemnation of the religious press for the iniquity of advertising such medicines, such papers as *The Churchman*, *The Living Church*, and *The Standard* do not come under the ban.

"It ought also to be understood by the public that the Protestant Episcopal Church in the United States has no official organ, that so-called church papers are purely personal enterprises or private corporations, and that the church as such cannot be held responsible for the published articles or the printed advertisements in such papers.

"In view of these facts, your Committee would recommend to the three papers here named that by editorial, or in other way that their editors may see fit, this subject of the deleterious influence of Alcoholic proprietary medicines be fully exploited in their estimable columns.

"Your Committee would further recommend:

"1. That this Society carefully watch legislation at Albany, with intention at any available opportunity to support any reform measures on this subject, careful in doing so to advise with Boards of Health or trustworthy chemists and physicians to make their position tenable and their assertions true.

"2. That clergymen be requested both in direct conversation and public discourse, when advisable, to condemn the use of such dangerous medicines that are training a generation of drunkards, and above all to refrain from giving testimonials and lending their portraits for the benefit of patent medicine dealers, a thing that has already brought reproach upon the sacred calling, and is doing much harm to the cause of religion.

"3. That these statements and recommendations of your Committee be sent to *The Churchman*, *The Living Church*, and *The Standard*, with the request of the Church Temperance Society that they be printed in an early issue of such paper.

"All of which is respectfully submitted,

"GEORGE R. VAN DE WATER (*Chairman*).

"ROBERT L. PADDOCK,

"ANDREW H. SMITH,

"JEROME WALKER,

"Committee."

### The Recent Lowering of Fees for Life Insurance Examinations.

Several years ago the Equitable Life of New York and the New York Life Insurance Companies determined to reduce the amount paid for an ordinary examination from \$5.00 to \$3.00. The opposition to this made by the doctors was so great that both companies went back to the old rates.

Recently several of the old line companies, notably the Mutual of New York, the Equitable and the New York Life, have proposed a graded rate of fees, as follows: For \$3,000 or less, \$3.00. For over \$3,000 and less than \$25,000, \$5.00. For \$25,000 and less than \$50,000, \$7.50. For \$50,000 or over, \$10.00. An extra allowance of \$1.00 is allowed where an additional specimen of urine is required. The companies claim that this reduction is rendered necessary on account of the tremendous pressure brought against them for the curtailment of salaries and expenses in every way. It is also claimed that the grade of policies written now are much smaller than formerly, and consequently the incomes derived from them are proportionately less. One of the reasons given for making the fee proportionate to the amount of the policy issued is that the applicant is better able to pay a larger fee for a large policy than for a smaller one. On the other hand, the doctors maintain that they have rendered a certain service and that they should receive a certain fee for the service rendered without any reference to the amount of the policy. It is generally considered that the fee for the chemical examination of the urine should be \$2.00, and that for a full examination, including urinary analysis, should be \$5.00. The insurance companies have entirely overlooked the fact that the service rendered by the doctors is far out of all proportion to the remuneration received. If an examiner, by his skill and knowledge, saves the company a \$5,000 loss by one examination, he has saved them perhaps more than they will pay him in an entire lifetime. Therefore the medical examiners are the backbone and sinews of the company, as it is on the result of their

work they fail or succeed. The companies will doubtless learn, to their cost, that they can ill afford to curtail the already meager fee paid to their medical examiners. It remains to be seen what action the state and county associations and the American Medical Association will take in regard to the matter. There are always a class of men who are so anxious for business that they will consent to anything in order to get it. It will be a great pity if this class is allowed to influence or control those who respect themselves and their profession more.

W. T. P.

### ORIGINAL ARTICLES.

#### FLAT FOOT, FROM THE PHYSICIAN'S STANDPOINT.

BY THEODORE POTTER, A. M., M. D.  
INDIANAPOLIS, IND.

Professor of the Principles of Medicine and Clinical Medicine, Indiana Medical College.

The counterfeits of rheumatism make up one of the interesting and important groups of maladies with which all practitioners are called upon to deal. The word rheumatism has, in the popular, and even in the professional mind, such an indefinite significance that all of the aches and pains about the locomotive apparatus are apt to be classified loosely under this term. Hence, patients constantly come to us in private practice, and still more frequently in dispensary clinics, complaining of rheumatism, when in reality they are suffering from traumatic or other forms of lumbago, from Potts' disease, from sciatica, so often and so mistakenly called sciatic rheumatism, from incipient hip-joint disease, knock-knee, or rachitically bent bones, from flat foot or some other form of talipes, from metatarsalgia, the so-called Morton's disease, or from gonorrheal, scarlatinal, diphtheritic or other forms of infectious or toxic arthritis. When to these are added the various forms of traumatic, toxic, and trophic affections of muscles, of ligaments and other fibrous structures, all of which so often masquerade under the name of rheumatism, we can not but be impressed with the almost meaningless use of this word and with the need



for reform in this field of clinical nomenclature. And, while it is true that rheumatism may occasionally cause or influence some of those affections which are not usually rheumatic in origin, we must not overlook the fact that they are in most instances different in origin and course from the diseases of the joints and other fibrous structures resulting from acute articular rheumatism. And, as they are different in origin and course, so do they call for different treatment. This clinical fact remains true even though it be also true that we do not yet know just what is the real nature of rheumatism. Just so long as we keep up the old error of using the terms gonorrheal rheumatism and sciatic rheumatism, just so long will we help to perpetuate the diagnostic and therapeutic errors which follow. I have, in recent years, made it a matter of special effort to point out to students in dispensary and hospital clinics the danger of misusing this term rheumatism, and the mistakes in treatment which have resulted from it. The attention of the profession has of late been called to this matter of the classification of the so-called rheumatic disorders and of the clinical errors which attend it, notably by the papers and discussions at the last two meetings of the American Medical Association. There is a call for reform in the use of the term, and in the pathological and clinical conception of rheumatism, and this paper upon flat foot, from the standpoint of the physician, is chiefly intended as a contribution toward that happy end.

The human feet present two conspicuous arches, one antero-posterior, the other transverse. Into the normal anatomy of these arches, and their pathological anatomy in connection with the deformity called talipes valgus, or flat foot, I shall not enter more than to call attention to two or three facts of special clinical significance. I shall speak especially of the acquired form of the disorder, or of that form in which the foot, perhaps slightly congenitally deformed, becomes more distorted with passing years, or under special strains. When the arch of the foot lets down, the foot becomes flat-

tened antero-posteriorly. At the same time the transverse arch becomes flattened, the foot rolls outward, and hence the prominence of the inner malleolus. The result of this mal-position in standing and walking is, first, a strain upon the ligaments; second, strain upon the tendons, and third, new points of pressure upon the bones of the foot and ankle. But this is not all. The mal-position of the foot may result in corresponding malposition and therefore strain upon the knee and hip joints. Hence, the person suffering from a considerable degree of flat foot is apt to suffer not only from these strains and new points of pressure in the foot, but in the knee and hip also. This latter fact explains some misleading symptoms which may suggest even strongly the mistaken diagnosis of rheumatism. With the strain upon ligaments and tendons comes pain in the foot and often in the leg. With the mal-position of the bones and the consequent development of abnormal points of pressure comes often that peculiar, deep-seated ache so suggestive of bone soreness. For, indeed, there is not infrequently developed a low grade of bone inflammation, and this is especially likely to occur and to present its characteristic symptoms if the arch has rapidly let down, the bones have become rapidly misplaced, and therefore the points of abnormal bone pressure have been rapidly assumed. It will readily be seen how such a condition of things may give rise to pain, tenderness, redness and swelling, closely simulating the local lesions of articular rheumatism. And if to these symptoms and physical signs in the foot there be added some pain, tenderness and even swelling at the knee, and pain and tenderness at the hip, the deception becomes all the more complete. If, further, there occur, in connection with this arthritis, which, under a rapid prolapse of the arch or some special strain of the foot, may assume an acute form, some slight fever and general malaise, it is not surprising that the picture of an acute articular rheumatism may be practically complete.

Acute articular rheumatism is, in a

large proportion of cases, polyarticular. And when the patient has had recurrent attacks, this feature of the disease is almost always conspicuous.

Chronic rheumatism, a quite different affection, is also usually polyarticular, begins usually after middle life, and is comparatively seldom a sequel of true acute rheumatism. The feet are not favorite seats of its election, especially in its earlier position. If these facts are kept in mind, they will go far toward eliminating errors in diagnosis between these diseases and flat foot.

The fact that a person has had so-called rheumatism confined to his feet for months or years should at once suggest the non-rheumatic character of his trouble, and that even without a direct physical examination.

The following cases will illustrate some of the points which I am endeavoring to emphasize:

Case 1.—Mr. H., aged 35, a commercial traveler, came to me some years ago complaining of severe rheumatism in both feet, together with distressing lumbago, which he described as rheumatism, in his back. He had suffered from these afflictions with increasing severity for a number of years, until he had become almost, and at times completely, incapacitated. He had, as he said, taken gallons of rheumatism medicines, had visited several of the neighboring mineral springs, had gone to Hot Springs, Arkansas, all without any considerable or lasting relief. Examination revealed typical flat feet of high degree as the cause of all his trouble. An operation should probably have been done, but, refusing this, his disabilities were in a fair degree relieved by the application of braces, under the direction of the late Dr. Morsee. This case illustrates the too common error of applying the term rheumatism to the disorders caused solely by flat foot; the production of severe and obstinate lumbago by the same foot deformity, and the unfortunate expenditure of time and money by the patient, and his arrival at a high degree of deformity and suffering, all because of the loose use of the term rheumatism coupled

with and doubtless partly responsible for failure to carefully examine his feet.

Case 2.—Mr. B., aged 27, foreman in a wholesale hardware store, had suffered from repeated attacks of acute articular rheumatism, affecting many joints, including his feet. I had seen him in several such attacks. He had for years had some trouble with his feet, and each succeeding attack of rheumatism left him with this trouble increased until he was at times almost unable to walk. He obstinately insisted that the rheumatism had become chronic in his feet. But, my attention being called to it, I recognized the typical lesions of flat foot and, with some difficulty, persuaded him to seek surgical aid. Under mechanical treatment, including the wearing of properly adapted shoes, his chronic rheumatism of the feet disappeared and he was able to resume and continue his work. This case illustrates the fact that true articular rheumatism may cause or aggravate a letting down of the arches of the feet. At the same time it illustrates the importance of distinguishing between the poly-articular causative disease and the resulting purely local deformity. For while this man's attacks of rheumatism were promptly controlled by medical treatment, no amount of medication did or could have cured his flat feet.

Case 3.—Mr. S., aged 30, a commercial traveler, in the winter of 1897 changed his occupation and became a clerk in a retail store. Here he was constantly on his feet for many hours daily and until nearly midnight on Saturdays. As a result, he began to suffer from what he called rheumatism in his feet, the deception being increased, in his own mind and in mine, by the fact, afterward made plain, that the handling of heavy articles had strained and given rise to pain and soreness in his shoulders, wrists and back. He went to Martinsville Springs, rested, bathed, became much better, and returned to his work. He was accustomed to ride a bicycle to and from his store, and, with the advent of hot weather, adopted the prevailing fashion of wearing soft bicycle shoes, which gave little support to the arches of his feet.



Losing this support, and being constantly on his feet, his muscles relaxed by the hot weather, he came to me complaining of what he thought, and what closely resembled, an attack of acute rheumatism in his feet. His feet were painful, tender, the ankles red and swollen. The pain extended up his legs, the knees were painful and tender, and the hips were also somewhat painful. With it he had a slight fever, headache and general malaise. My suspicions being aroused by the suggestive history of his change in occupation and habits, I was led to a diagnosis of acute flat foot instead of acute rheumatism. Appropriate treatment resulted in prompt and lasting relief from his suffering and disability.

Case 4.—Mr. G., aged 38, a railroad brakeman, had suffered with increasing severity for years with what he supposed to be rheumatism in his feet, but which I found to be simply flat foot. So severe had his suffering become that he had been forced to give up his position. I shall call attention to only one interesting feature of his case. Being told that he was not suffering from rheumatism, he at once became interested because, he said, he was always worse in summer, and he had himself thought it strange that his rheumatism should thus increase with the warm weather. The explanation was not far to seek. In common with railroad men, he wore heavy, stiff-shanked shoes in winter, which supported the arches of his feet. In summer he changed to thin, light-soled shoes, which let down the arches and soon gave rise to an increase in his pain.

I will not further multiply the relation of cases illustrating the symptoms of flat foot and the reasons for the frequent failure to recognize it. Sufficient has been said to show how often and why it may give rise to symptoms suggesting and even closely simulating rheumatism, and to warn us all to be on our guard lest, through persistence in the slipshod use of the term rheumatism, together with failure to properly examine people suffering from painful feet, we subject ourselves to mortification and our patients to needless suffering. Let us remember that the

man who complains of persistent rheumatism confined to his feet is usually the subject of talipes.

#### BRONCHOPNEUMONIA.\*

EDGAR A. HINES, M. D.,  
SENECA, S. C.

A careful study of the subject of pneumonia necessarily carries one into the history of the development of the science and art of medicine, and discloses the fact that in some respects we are far in advance of our forefathers, while in others we have made but little progress, indeed, may have retrograded. Pneumonia continues to show such an alarming rate of mortality, and even increasing, that it is no wonder all the scientific world seeks a specific. New York City has recently appointed a commission of learned clinicians and pathologists to make a special report upon this disease with the hope that something may be done to stay its ravages. For many centuries inflammations within the chest cavity have been recognized, but not until auscultation and percussion as means of diagnosis were discovered, was there any successful attempt to differentiate the different forms of pneumonia.

To recall to your minds the intellectual darkness preceding these discoveries, permit me to quote from a valuable work, which I show you here, by William Cullen, professor of practice in the great University of Edinburg in 1785—two hundred and twenty-one years ago. Chap. VI. Pneumonia, or pneumonic inflammation. Under this title I mean to comprehend the whole of the inflammations affecting either the viscera of the thorax or the membrane lining the interior surface of that cavity; for neither do our diagnostics serve to ascertain exactly the seat of the disease, nor does the difference in the seat of the disease exhibit any considerable variation in the state of the symptoms, nor lead to any difference in the method of cure. As bearing upon the causes we shall discuss further on, I beg to quote again from the

\* Read before the Fourth District Medical Association, Greenville, S. C., Feb, 5th, 1906.

same author: "The pneumonic inflammation has been sometimes so much an epidemic as to occasion a suspicion of its depending upon a *specific contagion*; but I have not met with any evidence in proof of this."

Cullen made many dissections of persons dead from pneumonia, including children, and described with considerable accuracy pathological lesions, but still he was ignorant of the different forms of the disease as we know them to-day.

About a quarter of a century after the publication of these observations, Laennec, the distinguished French physician, gave to the world his stethoscope. But, strange to relate, the different forms of inflammations within the chest were very obscurely portrayed even a hundred years later, by a number of writers I examined. And just at this point I shall speak more definitely of bronchopneumonia. I have been unable to learn the exact time and by whom the disease was first clearly diagnosticated. It is probable, however, that one of the first decided efforts made in this country to extricate the term bronchopneumonia from the tangled skein of more or less confusing synonyms, was William Pepper, in 1885, in *Pepper's System*. He begins his article on this subject thus: "Bronchopneumonia: Lobular pneumonia. Although numerous other names have been used to designate this affection, it is undesirable to perpetuate them. To Delafield, of New York, in his pathological anatomy published about this time, belongs much of the credit for clearly defining the condition. No small influence at this period and later was the improvements in the microscope, and greater skill in the art of auscultation and percussion. I shall be only too glad if I prove to you that I am speaking of a disease which may well command the attention of the most learned among you, and thus inspire you with greater zeal in a fight which has by no means yet been won—viz.: the easy diagnosis of the affection and its satisfactory cure. No person is exempt from bronchopneumonia, and hence do not permit yourselves to be lulled into a careless attitude

when you have before you a patient under four years or over sixty, and therefore feel safe in *guessing* you have a case of bronchopneumonia. To understand its protean symptoms which I shall not weary you with reciting, requires a profound knowledge of anatomy, physiology and pathology, especially of the child, for it is in childhood that by far the greatest number of cases are seen. The causes are not even yet all clearly understood. The relatively smaller air cells in the child is a great factor. Cold is certainly a marked predisposing cause. So great an authority as Loomis in 1890 states that bronchopneumonia is always secondary. Holt, however, in his latest work, 1905, gives us the results of his extensive observations and in an analysis of the relative frequency of lobar and bronchopneumonia in 370 cases in the New York Infant Asylum, found 261 bronchopneumonia, 109 lobar pneumonia, and in another series of 426 cases found 164 primary, and the rest complicating bronchitis, measles, pertussis, diphtheria, acute ileocolitis, scarlet fever, influenza, varicella and erysipelas. We are indebted to bacteriology for much of our recent knowledge in regard to the causes of bronchopneumonia, which has again been briefly summarized by Holt as follows: In the primary cases the pneumococcus is nearly always present, and in a large proportion of the cases it occurs alone. In cases of mixed infection it is most frequently associated with the streptococcus, and next to this the staphylococcus pyogenes aureus. In the secondary cases a large variety of bacteria may be concerned.

One of the most common complications which you are each one in general practice meeting daily is influenza. I show you here some fine specimens of these potent causes of bronchopneumonia as we know it to-day.

These discoveries have led to the placing of bronchopneumonia in the category of infectious diseases, and I here exhibit one of the first books within my knowledge, translated from the German and published in September, 1905, *Modern Clinical Medicine: Infectious Diseases*.



Professor Leyden, of Berlin, writes exhaustively in this volume of pneumonia. So much for the etiology. A disease which at one and the same time may have actually in progress these various organisms, with their peculiar lesions, exhibiting an apparent lobar pneumonia, perhaps, in one section of the lung, a pleurisy in another, a number of scattered consolidated lobules no larger than a quarter dollar, various stages of engorgement of the air cells and bronchioles, and yet resolution at still other points, believe me, requires no mean skill to differentiate. The physician should be familiar with every known aid in diagnosis and be master of auscultation and percussion. The ear should be cultivated in immediate auscultation, but just the same as the high power of the microscope is necessary to bring into clear view the whole picture, so is the stethoscope necessary. I show you one (1) used by many pediatricists, which has a  $\frac{3}{4}$ -inch bell, and is very important in examining a small spot in a small lung—especially in the apex and high in the axilla. The phonendoscope is valuable, as it intensifies the sound, and can be used over the clothing if demanded. Be familiar with all these methods if you would be fully armed. The treatment of bronchopneumonia, a disease which may run ten days or as many weeks, having no definite time to cease at the mandates of *vis medicatrix naturae*—can not be carried out like that of lobar pneumonia, and as I saw Professor Osler do some years ago. In presenting a case of a young child, he said: Gentlemen, the treatment of many cases of lobar pneumonia depends largely upon the age of the doctor. If you have just graduated and hung out your shingle, you would better give the patient purges, expectorants, and use mustard plasters, blisters and poultices freely. If you have practiced ten or fifteen years, you may be less strenuous and leave off some of these remedies—but if you have reached the age of fifty, you can treat the patient from beginning to end as you have seen me do without a single dose of medicine. There has been no specific serum yet

forthcoming that offers much hope of cure, and, as I remarked in the beginning, we may have made but little progress in the treatment of pneumonia. We have almost abandoned bleeding and blistering, which are no doubt sometimes valuable—and it is interesting to note that the learned and celebrated Dr. Arbuthnot, nearly two hundred and fifty years ago, in England, used these words in speaking of the treatment of pneumonia: "The steam of warm water taken in by the breath serves as a kind of internal fomentation and helps to attenuate the impacted humors." Holt, in his recent book, says: Inhalations are of more value in relieving cough and in promoting bronchial secretion than any other means we possess. I have been informed that he has regular steam chambers for the treatment of his hospital patients. I have nothing new to offer you in the treatment of this disease. Hygiene is of the greatest importance. I combat high temperature with the warm bath, sponge or pack. These cases bear cold poorly, as a rule. Counterirritation is of great value all around the chest with mustard, and kept up for days, applied at intervals. The cotton batting jacket is useful and also hot poultices in some cases. Dovers powder in very small doses is worth much to relieve pain and cough. The stimulants I depend upon are strychnia, whiskey or brandy and aromatic spirit of ammonia. A good nurse, with all that good nursing means to-day, is, as in enteric fever, the physician's greatest ally. I have paid the very closest attention to the best methods of dieting these little patients, and have felt myself rewarded many times. In conclusion, I beg to present the latest thought from the greatest center of clinical medicine in the world to-day, as recorded by Professor Leyden, of Germany, and as a summary of his treatment of pneumonia. At the present time therapy is an art, or, better, the artistic waging of a battle against disease. The weapons for this battle, i. e., the individual therapeutic remedies and methods, may be shown, their manner of action and indications may be described, and, in general, the plan for proper treat-

ment may be indicated—but something still remains, the proper choice and use of remedies suitably and correctly chosen according to the special indications of the disease and the peculiarities of the patient. Under the present complex conditions, the practical physician in the special case must himself select what is suitable. The result will always depend upon his firmness, care, and decision, which are partly the results of good training, but to an equally great degree are qualities of endowment, and dependent upon his own personal culture.

#### SOME REMARKS ON LACHRYMAL STRICTURE, WITH EXHIBITION OF NEW INSTRUMENT.\*

J. W. JERVEY, M. D.,  
GREENVILLE, S. C.

Concerning the detailed *modus operandi* of tear drainage from the conjunctival sac, little is vouchsafed in the text books on the eye. The canaliculi, lacrymal sac, and nasal duct of each eye are of course designated as the drainage canal. The actual process of this drainage is, however, a mooted point. Capillary attraction, gravitation, and suction from the nasal chambers in the process of breathing, are various theories. The first and last of these are doubtless worthy of serious consideration, as being partial agents. The gravitation theory, I should say, might be summarily dismissed as untenable. An individual standing on his head is not unduly annoyed by epiphora, whatever his other sensations may be.

To my mind it is probable that the contractions of the orbicularis palpebrarum muscle toward its point of origin, as observed in the frequent act of nictitation, or blinking, cause a marked dilatation of the lacrymal sac, while the fibres from Horner's muscle, which twine around the canaliculi, contract concomitantly, and while shortening, at the same time enlarge the lumina of these

little passageways. The nasal end of the duct is marked by a slit-like opening in the mucous membrane under the inferior turbinate, and is guarded, in probably all normal cases, by valvular action.

However, regardless of the theories of physiological lacrymal drainage, it is a rather common thing to meet with stricture or even atresia at some point in the canal, from the punctum to the nasal orifice. In the vast majority of cases these strictures are directly due either to catarrhal swelling of the mucous lining in the canal, or to the formation of fibrous connective tissue bands as a result of chronic inflammation. Treatment, especially of the latter class of cases, is usually unsatisfactory. The old surgical motto: "Once a stricture, always a stricture," holds good in the case of the lacrymal canal, as it does referring to the urethral passage.

Dilatation (with, of course, appropriate topical applications) is the principal indication. This is accomplished usually by means of a series of graduated probes. I regret to say that I believe it to be largely habitual with many eye surgeons to split the canaliculus before introducing a probe. In fact, I have had more than one well-known ophthalmologist inform me that it is practically almost never possible to probe the canal without this preliminary splitting, and I have seen a good many eyes thus summarily dealt with, and with ultimately very unsatisfactory results.

However, it can readily be demonstrated that it is not only possible but extremely easy and simple to pass lacrymal probes up to any reasonable size through the vast majority of canals without recourse to the severance of a single fibre of tissue. The anatomy and physiology of the parts demand that surgery in these cases should be scrupulously and consistently avoided unless imperatively necessary. Occasionally the punctum may be safely split for a distance of not more than about two millimeters.

I have here a little instrument which I was enabled to perfect about two years and a half ago, which can almost always

\* Read before the Tri-State Medical Association of Virginia and the Carolinas, White Stone Lithia Springs, S. C., Feb. 27-28, 1906.



be passed (after slight dilatation of the punctum) the entire length of the lacrymal canal with no preliminary surgical intervention whatever. You will readily see the principle upon which it works (Exhibits Jervey lacrymal dilator, made by Meyrowitz, N. Y.). It has the conspicuous advantage of exerting most pressure at the point of greatest constriction, and, while dilating the passage, permits antiseptic flushing with a syringe at the same time.

The whole process, including dilatation to any desired extent, can be accomplished entirely painlessly, after suitable preparation with adrenalin and cocain. And let me say right here that in these cases, no less than in other surgical conditions, a *painless procedure* means a *pleased patient*. It is an altogether worthy goal to strive for, and very satisfactory when attained.

In these cases, as in others, when cutting is unavoidably necessary, I cut—in authoritatively prescribed fashion; but a million or so years of evolutionary development have perfected structures and functions in the human system which I do not care to attempt improvement upon by surgical solutions of continuity unless insistently compelled to do so.

I do not claim any extravagantly astonishing line of cures with this little dilator. However, I have been enabled to get more satisfactory and lasting results by its use than by any other method; and a number of intelligent patients formerly treated in the old-fashioned way by myself and others have felt and appreciated its usefulness. If properly and carefully used, I believe it will prove itself, and I present it on its merits.

#### REPORT OF CASE.\*

J. B. HUGHEY, M. D.,  
GREENWOOD, S. C.

Tuesday, February 20th, 1906, I was called to see Frank A., aged 15 years, a strong, muscular boy.

*History.*—He was taken sick with nausea and vomiting Saturday night previous. He was given some domestic remedies and was better Sunday. Was feeling badly on Monday, cough bad, expectorating some bloody sputa. He was given some purgative remedy, and was easier towards night and fever cooler, but during the night became very restless and distressed, with fever high and painful cough. At 8:30 a. m. Tuesday this was his condition: Temperature 103 4-5°, respiration 40, pulse 110, cough painful, expectoration scanty and frothy, stained with blood, an anxious, distressed expression of countenance. Physical examination revealed the lower lobe of right lung solid, fine crepitant rales in the middle lobe. The tongue had a heavy coat of light brown. Stools had been frequent, of dark color and offensive odor.

*Diagnosis.*—Pneumonia, with lower lobe consolidated and middle lobe in the congestive stage.

*Treatment.*—Four tablets, each containing ½ gr. calomel and ½ gr. podophyllin; one given every hour. These were given for their therapeutic effect, viz.: antiseptic, laxative and diuretic, also to stimulate the secretory and excretory cells of the whole body. These were followed in regular order by a dose of ½ ounce castor oil, for its well-known effect of stimulating peristalsis and evacuating the foul, undigested contents of the intestinal tract. Thus, by these remedies, through their therapeutic effect, I hoped to reduce the toxemia and, as it were, to set up again that vibratory electric current so essential to physiological cell function, which had evidently been broken. I also gave at once four drops of tr. aconite root, followed every hour by two-drop doses. This was also given for its legitimate therapeutic effect, viz.: the reduction of the power and frequency of the pulse beat by slowing the heart action and dilating the arterioles of the whole body. Thus in large degree relieving the local engorgement and giving the leucocytes room to work and perform their normal police duty. In the afternoon there was slight improvement all

\*Read before the Greenwood County Med. Society March 5th, 1906, and by request of Society sent to the JOURNAL of the South Carolina Medical Association.

along the line. Was restless during the night, but did not require an anodyne. Hourly doses of aconite were kept up.

21st, Wednesday, 8:30 a. m.: Temperature 102, respiration 34, pulse 95, soft but full, expectoration free and easy, with but little blood. Lower lobe still consolidated. Anxiety and distress of countenance very much relieved.

To the hourly doses of aconite was then added 3 grains quinine every four hours and 4 grains mur. ammon., 2 gtt. tr. aconite rad, 1-15 grain sparteine. I made this addition because I had a consolidated portion of lung. The quinine was given for its leucocytosis and stimulating effect. The ammonia was given to soften the mucus blocking the lung and to stimulate its expulsion by cough. The aconite to reinforce that already being taken. The sparteine was given to slow and strengthen the heart's action, also to assist the aconite in its vaso-dilator effect.

4:30 p. m.: Temperature 101°, respiration 25, pulse 85. No blood in sputa. A dose of ½ ounce castor oil was given as stools were still dark, with some odor.

22nd, Thursday, 9 a. m.: Had rested well during the night and had gentle perspiration since 4 o'clock. Temperature 100°, respiration 22, pulse 68. Rales gone from the middle lobe, which was found to be clear. Same treatment continued except the hourly doses of aconite were put to two hours with instructions to extend to three hours if the perspiration increased or return to hourly doses if it dried up. These instructions were not carried out and, as a result, the afternoon temperature ran up to 102°. The middle lobe remained clear and there was no more bloody sputa. The hourly doses of 2 gtt. aconite restored and ½ grain calomel and ½ grain podophyllin given.

23rd, Friday, 8:30 a. m.: Temperature 101°, respiration 22, pulse 75. Not much expectoration, but what there was caused but little effort and consisted of large, heavy, cream-colored lumps.

5 p. m.: Temperature 100°, pulse 70, soft but plenty of volume. Expectoration free and copious of the heavy,

creamy sputa. Air was passing freely into the lower lobe. Appetite for the first time became insistent. There had been but little nourishment taken up to this time. Bowels moved freely, with bright yellow stools. The hourly doses of aconite put to two hours, with caution to stop entirely if perspiration increased too much and to give a little whiskey if much depressed.

24th, Saturday, 8:30 a. m.: Temperature 99°. Wanted to get up and had the strength to do it. A few coarse rales left. Little cough and expectoration. I ordered him to remain in bed twenty-four hours longer. Three grains quinine every six hours, 4 grains mur. ammon., 2 gtt. aconite, 1-15 grain sparteine, 6 hours, were continued. Liquid nourishment freely.

4 p. m.: Temperature 98 2-5°. Resting well and in a good humor, eating all he could get.

25th, Sunday, 9:30 a. m.: Temperature 98 2-5°, respiration 18, pulse 70. The whole lung clear, no cough and had slept well all night. Was very hungry and anxious to get out of bed.

I ordered light diet in liberal quantities; 3 grains quinine every 6 hours for two or three days; allowed him to get up and dismissed the case.

### ILEO-COLITIS.

C. C. GAMBRELL, M. D.,  
ABBEVILLE, S. C.

*Mr. President and Gentlemen—*

As was announced at our last meeting, our subject for to-day is "The Summer Complaint of Babies." On investigation I find this term embraces too many diseases for me to cover in this paper, so I have endeavored to confine myself to Ileo Colitis, or Dysentery, in children during the second summer of their lives.

Ileo-Colitis, as the term implies, is any inflammation of the ileum and colon, but for consideration we will divide this into three different varieties, viz.: Acute Catarrhal Ileo-Colitis, Follicular Ileo-Colitis and Membranous Ileo-Colitis.

*Etiology.*—All the above forms are considered infectious. They may occur



as acute primary diseases, but more often in this climate follow diarrhea which has been produced by overfeeding on milk of a poor quality, or from some fruit or vegetable diet given the child by a careless nurse. This diet may be loaded with bacteria or act as a fine medium in which the bacilli which are already in the intestines may and can thrive. Also acting in many cases as a mechanical irritant, inflaming the mucous membrane and allowing the bacteria an entrance to the deeper structures.

Flexner has demonstrated that in the majority of cases the disease is not wholly due to the amoeba coli, but largely to the mixed infection. The principal etiological factors we have to deal with are usually one little strawberry, just one mouthful of potatoes, beans, bananas, green apples, lemon peeling, peaches, and quite a number of other harmless things that adults are accustomed to eat with relish.

*Symptoms.*—In simple acute Catarrhal Ileo-Colitis, the symptoms in a case seen early are very unsatisfactory. You will usually find the temperature elevated, ranging from 99 to 104. Pulse excited, skin moist and cool, feet cold and head hot, and child restless. The abdominal muscles relaxed or distended, according to the amount of gas in the intestines.

The mother will give you a history of the child's bowels having moved two or three times during the morning, with a few streaks of blood in the actions. On examining the stools you will find them very acid, with marked odor, and containing undigested curds of milk and food, also a quantity of mucus and blood. On inspecting the child's buttocks, you may find them inflamed, and very much irritated. At first there is little tenesmus, but later on it will be increased. Vomiting may occur, but as a general thing it does not until after the second or third day, when the nerve centers are more involved by the poison. In most cases the child is very restless, and if the temperature is not controlled, it will have convulsions. The appetite is very much lessened, and you will have trouble to

get the child to take nourishment enough to sustain strength.

In follicular Ileo-Colitis all the above-mentioned symptoms are very much more marked. The child does not respond to treatment unless a few follicles only are involved. The majority of cases die during the second week of illness. Pseudo Membranous Ileo-Colitis is very rare. It is the form that is usually spoken of as sporadic dysentery. It is diagnosed by the very high temperature from the outset. Temperature ranging from 105 to 106. The stools are composed almost entirely of blood and mucus from the intestines. The child very rapidly becomes emaciated and usually dies within three or four days.

*Diagnosis.*—Ileo-Colitis is diagnosed from fermented diarrhea, by the continued fever, the more frequent discharges and the small quantity in each stool, the presence of blood and mucus and the tenesmus. Ileo-Colitis is diagnosed from cholera infantum by the absence of continuous vomiting, thirst and the serous watery stools, as well as the physical appearance of the little sufferer.

*Prognosis.*—The prognosis in simple acute ileo-colitis, without ulceration, is very favorable, but few cases where ulceration takes place get well. They will often hold on for weeks and weeks, but usually succumb. The majority of cases, however, where treatment is instituted early will get well in from ten to twenty days, but they are usually slow in regaining their normal strength.

Practically all of the cases of follicular and membranous variety die usually before the diagnosis is made.

*Treatment.*—Treatment should be instituted early, but this we seldom have an opportunity of doing, for most parents will try all kinds of teething powders, soothing syrups, or simply say the child is teething, and will not do anything until the disease has gained great headway, and is producing marked systemic effects. To begin your treatment, you should first withhold food or decrease it to the minimum. If it is a breast-fed baby, tell the mother she must nurse it only at stated intervals; if it is

a bottle-fed baby, you had better stop the milk at once, and put it on chicken or beef soup, barley or rice water, or one of the prepared foods, very much diluted. One of the best substitutes in my cases has been the old-fashioned kettle tea with just enough milk in it to color the water. If you will put a small amount of sugar in this, the child will take it with great relish. It is a very hard matter to decide at first what you will resort to as a foodstuff, for in this matter you will find that the mother has had so many suggestions from outsiders that she will be very much prejudiced against nearly everything you may suggest, or will prepare it in such an indifferent manner that you cannot be certain what it will contain when she gives it to the little sufferer.

Sterilized or boiled water with ice and lime water added should be given often, in fact it should be offered to the child every few minutes. In over two-thirds of the cases of ileo-colitis, the children do not get enough water to drink, many parents telling you the child drinks too much water, and I guess this is true, if the water is not of a suitable quality.

My first medicinal treatment is to give the child a medicine that will unload the intestine of any irritating foreign matter that may be in it, and at the same time act as a soothing agent to the inflamed mucous membrane. I find castor oil one of the best for this, and to a child one year old I give one or two teaspoonfuls, adding to this a few drops of turpentine or paregoric. Following this oil I give an antiseptic powder containing calomel, bismuth, salol and soda. The calomel in this mixture not only stimulates the flow of the bile, which is a fine antiseptic, but is one of the best antiseptics itself. The bismuth is a metallic astringent and coats over the inflamed surface of the mucous membrane, thereby stopping the irritating effects of the intestinal secretions. Salol is said to be a very fine intestinal antiseptic, but it does not seem to be lauded so highly now as in former years. The soda is given to neutralize the intestinal juices and thereby helps to

allay the inflammatory effects. Usually, in addition to the above powders, I leave a few powders containing Dovers powders, bismuth and acetanilid comp. These powders are to be given every three or four hours, if the child continues restless and the fever high. The opium in the mixture allays nervousness, reduces the tenesmus and usually produces a refreshing sleep. The bismuth is given for the same purpose as above stated, for all the authorities tell us we must give it in large doses to get a good effect, consequently I am never afraid of giving too much in these cases. The acetanilid comp. is a good alkaline antiseptic, as well as one of the safest antipyretics. It also helps to allay nervousness. You will find that by giving these little patients a few hours' quiet sleep their chances of a rapid recovery are much augmented. The above treatment is about all I do for the first twelve hours. At the end of this time, if my patient is not better, I begin either a castor oil emulsion or a saline mixture, alternating with an astringent mixture. The castor oil mixture I usually use is composed of two drams castor oil, one and one-half drams bismuth, four drops carbolic acid, two drams listerine, one dram camph. tr. opii, one ounce ess. of pepsin, chalk mixture comp. two ounces.

The saline is composed of the following: Two or three drams sulph. mag., one dram tr. opii. camph., four drams aq. camph. and ad. menth. pip. enough to make two ounces.

The astringent mixture is composed of one dram tr. kino, one dram bis. sub nit, one dram tr. opii camph., one ounce ess. pepsin and mist. cretae co enough to make two ounces.

In addition to the above treatment I wash out the child's lower bowel once a day, using about one quart of sterilized water to which I add one teaspoonful of common salt. I often add to this one teaspoonful of borax, or boracic acid. In giving these colon injections, I prefer to use the regular Holt's colon tube. I find it is much stiffer than the soft rubber catheter recommended by some, and another advantage it has over the catheter



is your stream of water comes in direct contact with the mucous membrane of the bowels, and not to one small area on the side, as is the case with the catheter. If the fever is very high, I prefer cold water to warm. Whether I use warm or cold water, I leave a little in the bowels, for it will help to relieve the inflammation and replace the great quantity of fluid the system has been drained of. If the child is suffering pain and tenesmus, I have found a hypodermic of morphine  $1/100$  grain and atropine  $1/800$  grain to do incalculable good. Starch water and laudanum in small quantities thrown up the rectum has been highly recommended by Rotch and others. I have never tried it, but can readily see how it would give the desired relief. Neither have I tried the much-lauded cocaine suppositories, but I think they should be tried where other remedies have failed.

For supportive treatment, I rely on panopepton, peptonoids, brandy, beef or chicken broth. These should be given at frequent intervals, day and night, and in small quantities so as not to derange the stomach. In extreme cases, they should be given by enema, and especially when they excite vomiting.

In 1903 Flexner was experimenting with a serum for these cases, but as yet it has not appeared on the market, and I judge his efforts were a failure.

Tannic acid, 30 grains to a pint of water, and thrown high up the colon, has been highly recommended by some to decrease the amount of blood in the stools, but I have never obtained any marked results with it. It may have been that my solution was too weak, or did not get high enough up to reach the inflamed area. My experience with nitrate of silver has been equally disappointing. I think, as a general rule, we put these two drugs off as the last resort, and then discredit them if we do not get any good results, when, if they had been used earlier, our results would have been different.

For the inflammation about the anus and buttocks, which produces such pain after each movement of the bowels, I

have found that ten drops of carbolic acid added to one ounce of oxide of zinc ointment will relieve in one or two applications. It is a good practice to inspect often every child's anus and buttocks suffering with ileo-colitis, so that you will be able to stop these symptoms as soon as they appear. Mothers, as a general rule, will not mention it until the child gets so badly irritated that it will scream with pain every time the napkins are removed. These excoriations are much more easy to relieve in the beginning than when they have extended over the entire buttocks.

The after treatment of these cases is very important. You should return to diet gradually, and its effects on the alimentary canal should be watched closely. During convalescence it is not medicine they will need, but easily assimilated diet, plenty of pure, fresh air and out-of-doors life. The majority of my cases not being financially able to go to the mountains or seashore as recommended, I send them to some kind relative living a few miles in the country.

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#### TREATMENT OF WOUNDS.

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G. A. NEUFFER, M. D.,  
ABBEVILLE, S. C.

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For a proper understanding of our subject this morning it is necessary for us to first determine what constitutes a wound, and second to consider the various kinds of wounds; for all wounds do not require the same treatment. A wound is defined as "a sudden solution of continuity in one or more of the tissues of the body"—such a lesion occurring in bone or cartilage is, by common consent, called a fracture; and, although it is really a wound, it does not come within the scope of this paper.

Wounds are operative and accidental or intentional, and this has an important bearing both on the treatment and on the result to be expected. Operative wounds are wounds inflicted by the surgeon, for we must remember that every time we use the knife on a patient, no matter how small an operation it may be

from the lancing of a boil to doing a laparotomy, we are inflicting a wound—and this teaches us that we should make every effort to secure asepsis in small operations as well as large ones. And here it might be well to speak of the difference between antisepsis and asepsis. The meaning of antisepsis is “opposed to putrefaction.” This implies, of course, that we already have putrefactive changes going on in the wound, and that we are using means and remedies to stop them and to restore the wound to a normal healthy condition. The meaning of asepsis is absolute surgical cleanliness. If we secure asepsis, we prevent any putrefaction, any poisoning, any sloughing in the wound; then we have the surgeon’s desideratum. In inflicting operative wounds, the surgeon has every advantage, and should always obtain surgical asepsis. He has the time to prepare everything—to prepare his patient, to prepare the room (in major operations), to prepare his instruments, his dressings, and to prepare himself.

In accidental and intentional wounds, and these wounds in so far as the surgeon is concerned, present to him the same conditions, it is almost impossible to secure asepsis; the nature of the wound and the surroundings under which it was inflicted usually prevent such a result. Therefore, in these wounds, it is our duty to come as near asepsis as possible by making use of the most improved methods of antisepsis.

We now come to study the different kinds of wounds. These may be classified under five leading heads: Incised, punctured, lacerated, contused, perforating or gunshot wounds—any of these may become inoculated with a virus or venom—it is then a poisoned wound.

An incised wound is made by a clean cut with a sharp instrument; these generally bleed more at first than other kinds of wounds.

A punctured wound is caused by a narrow instrument which penetrates but does not cut laterally. These are considered the most dangerous of all wounds, because from their depth they are liable to implicate blood vessels, nerves, viscera

and other deep-seated parts of importance. Because matter when formed has no free exit, and is likely to burrow extensively. Because they are most liable to be followed by tetanus.

A lacerated wound is made by a dull instrument, which tears the tissues. These wounds are attended with less hemorrhage than the incised, both because their surface being irregular renders it easy for the blood to adhere and coagulate, and because arteries, when torn, do not bleed so much as when cut, but in other respects they are infinitely more serious. They are liable to inflame violently and slough, they are often complicated with foreign bodies, and are liable to occasion severe constitutional disturbances and tetanus.

A contused wound is one in which the tissues are more bruised than separated.

Perforating, or gunshot wounds are caused by missiles projected from firearms. They partake of the nature of three of the varieties of wounds already enumerated—the punctured, the lacerated and the contused—and present the dangers of all three of them. In gunshot wounds, shock is usually more severe than in other kinds.

Having given you a definition of what constitutes a wound, and made a brief study of the different kinds of wounds, with the characteristics of each, we will now take up the main question—the treatment of wounds.

When the process of repair secures the union of divided surfaces without suppuration, we have what is called healing by first intention or primary union. This is the ideal to be sought for whenever possible.

In the treatment of wounds there are four principal indications:

First—To arrest hemorrhage.

Second—To cleanse and remove foreign bodies.

Third—To bring the divided parts into apposition, and keep them so.

Fourth—To protect the wound from infection.

To stop bleeding is the first care of the surgeon in his treatment of a wound. The aim of the surgeon should always



be to secure the arrest of bleeding by means that shall cause the least disturbance in the future repair of the wound. Unnecessary ligatures are therefore always to be avoided. The size of the thread used for a ligature should be as small as is consistent with the strength required to occlude the vessel. The first and most generally applicable means for restraining hemorrhage is that of direct pressure made upon the bleeding point. This may be by the finger or by an instrument as a pressure forceps. In many instances the temporary use of pressure will be all that will be required for the arrest of hemorrhage that at first was very abundant. When copious and continuous capillary oozing persists, it may frequently be controlled by pressure with compresses wrung out in water as hot as can be borne by the hand. The use of heat as a hemostatic is to be preferred to cold, as being more favorable to local nutrition and subsequent active repair. The use of hemostatic forceps is a very efficient and convenient means of applying pressure. Many vessels which at first bleed freely, after a few moments of compression in this manner will no longer bleed when the forceps are removed. If the bleeding persists, torsion may be applied, which, being effectual in many instances, will reduce the ultimate need for ligatures to a minimum.

Of course, there are numbers of vessels that are too large, or that bleed with so much force that the best thing to do is to ligate them. In making a ligation, catch the bleeding point with a pair of artery forceps, and have the forceps held by an assistant. The selection of your forceps is important as there are innumerable styles and shapes of hemostats, and a great many of them are so constructed as to make it almost impossible to tie the artery, but you will find yourself tying the end of the forceps instead. I will show you some of the latest patterns. When you make your tie, always make your first knot, which we all know as the double-reef, or surgeon's knot. This will not slip. Then tie two ordinary knots. The material most generally used for ligatures is silk.

As a rule, hemostatic agents which produce tough clots of blood, as the salts of iron, or which are strong irritants, such as turpentine, or which destroy tissue outright, as the actual cautery, are to be avoided. Often when continuous oozing persists from a wound under a mass of soft blood clot, if the wound is freely opened and the accumulated clot thoroughly removed, further oozing becomes definitely arrested. A dilute solution of iodine has both hemostatic and antiseptic properties, and may sometimes be used with advantage. Iodoform added to a compress applied upon a bleeding surface has a distinct hemostatic effect.

From among all these resources the surgeon will be called in a given case to make use of those which shall be available, efficient, and least harmful.

Cleansing and removal of foreign bodies: The removal of foreign bodies will be much easier, both for patient and surgeon, if done at once than if delayed till inflammation sets in. Great care should be taken to remove from a wound all foreign bodies, whether they enter from without, as dirt, gravel, pieces of clothing, shot, wadding, etc., or be formed within, as pieces of bone, torn muscle, or blood clots. The means required for effecting such cleansing and removal must be adapted to the nature of the material to be removed. The forceps, scissors, curette, sponge, irrigating stream, each may find its use. The irrigation of a wound with normal salt solution will aid greatly in removing foreign bodies. When, however, a wound is already contaminated, it will be a good practice to irrigate it thoroughly for a considerable period of time with a germicidal solution of sufficient strength to secure the destruction of whatever septic material may have gained access to it. A solution of carbolic acid, 1/40, or of bichloride of mercury, 1/1,000, will be found most generally suitable for such a purpose. In those wounds where it is not possible to secure and maintain perfect cleansing, we must provide for drainage by packing lightly with some antiseptic gauze. Iodoform, boric, salicylic or iododysyl gauzes are used. The last named I have found

equally as efficient and free from the odor of iodoform gauze.

To bring the divided parts into apposition and keep them so: In the coaptation of wounds the aim of the surgeon must be to bring the several parts as far as possible into the same relations with each other as existed before the wound was inflicted. When important nerves, muscles and tendons have been divided, especial care must be taken to bring and secure together the divided ends. In bringing a wound together, much tension must be avoided, when operative wounds are drawn too tightly, stitch hole abscesses will result. When tissues are put unduly upon the stretch in an effort to bring them together, the circulation of the blood within them is impeded, nutrition is impaired, the formation of sloughs is invited, and suppuration promoted. We must also be careful to avoid strangulation of any portion of the tissue. Sutures too tightly drawn frequently cause necrosis of the wound edges.

The principal method of securing coaptation is by sutures. There are various kinds of sutures, but the interrupted is the one in general use. Catgut and silk are the materials that sutures are chiefly made of, silk being of most universal application. Whatever form of thread is used should have been rendered aseptic by previous preparation.

To protect the wound from infection: In the treatment of a wound after hemorrhage has been checked, its surface has been cleaned and purified, coaptation has been accomplished, and drainage provided for, a suitable dressing must be applied. Two main objects are to be accomplished by a dressing. First, the absorption of whatever secretions may come to the surface; and second, the protection from infection, injury and motion. Septic infection is to be guarded against by covering the part with soft and absorbent material that will receive and keep aseptic the discharges that drain away from the wound, and that will prevent the access of septic infection from other sources to the wound.

The best dressing is one of the standard sterilized gauzes, this to be covered by absorbent cotton, using very voluminous dressings, thus giving additional security against the conveyance of infection from without, and to protect it more certainly from mechanical violence and from motion.

Changes of dressing are made at long intervals, and thus rest is secured to the injured part while repair is going on. As to when such changes are required, the temperature is the most important indication, and the thermometer can be relied upon as an index to the character of the process going on in the wound. If, after an elevation of one or two degrees above normal for the first forty-eight hours after a wound has been inflicted and dressed, the temperature becomes normal and remains so, the surgeon can be assured that there is no reason for interference. If the temperature remains elevated, or rises again after having been normal, you may rest assured that things are not right within and that inflammatory and suppurative disturbances with retention of secretion and septic absorption are going on, and of course, a change of dressing is necessary. When the dressings become wet from secretions from within, you must change your dressings. If you have suppuration with sloughing, the dressings must be changed from day to day, or twice a day, often enough to provide sufficient drainage and cleansing of the wound. You should observe strict antisepsis in every dressing.

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## COUNTY NEWS.

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### LEE.

At the annual meeting of the Lee County Medical Society, held at Bishopville, S. C., on March 6, 1906, the following members were present: Drs. R. Y. McLeod, President; A. C. Baskin, Vice-President; L. H. Jennings, Secretary and Treasurer; J. B. Bullock, A. H. Brown, B. L. Harris, C. S. Britton, T. D. Foxworth, J. E. McLure.

The following officers were elected for the year 1906: Dr. J. B. Bullock, President; Dr. J. E. McLure, Vice-President; Dr. L. H. Jennings, Secretary and Treasurer.

Dr. B. L. Harris was elected delegate to the State Medical Association.



A Board of Censors was elected, as follows: Dr. A. H. Brown for the term of three years, Dr. T. D. Foxworth for two years, and Dr. C. S. Britton for one year.

The following resolution was unanimously adopted:

First—That we will not examine an applicant for insurance in an old line company for a fee of less than \$5.00, nor an assessment company for less than \$3.00.

Second—That the Secretary send a copy of these resolutions to every Life Insurance Company represented in Lee County, also a copy be sent to every County Medical Society in South Carolina and that the South Carolina Medical Society be notified of this action and that it be requested to uphold us in the same.

Dr. Le Grand Guerry of Columbia, S. C., gave an able, interesting, modern and scientific lecture on "Gall Stone."

Dr. Walter Cheyne of Sumter, S. C., gave a very instructive and practical discussion on "Nephritis."

The following resolutions were adopted on the death of our late brother, Dr. E. F. Darby:

First—We deeply lament the untimely death of our honored friend and brother. He was gifted in his chosen profession. None were endowed with more grace and skill than he; always ready to lend a helping hand to those in distress: ever ready and instrumental in organizing the profession. He was blessed with an intellect which few have, and was trained in the best schools of our country.

Second—That a copy of these resolutions be enrolled on a page in our minute book, also a copy be sent to the bereaved family, and a copy be sent to our county paper.

A resolution of thanks to Dr. Guerry and Dr. Cheyne was adopted by a rising vote. The society then adjourned to Durant Hotel for dinner, to meet again the first Tuesday in April at 11 a. m.

#### UNION.

##### RESOLUTIONS OF RESPECT.

At a meeting of the Union County Medical Society, held at their rooms on Monday, April 2nd, 1906, a committee was appointed by the President, C. Torrence, to draft resolutions upon the death of Dr. Wales G. Fike, a member of said Society.

WHEREAS, God, in His allwise providence, saw fit to remove by death Dr. Wales G. Fike from this earth on March 30th, 1906, be it

*Resolved*, first, That we bow in humble submission to His will, yet feeling that our Society has lost a most zealous, conscientious and honorable member.

Second—That the medical profession at large has lost an intelligent, ethical and charitable physician, and that the State of South Carolina has lost a good and faithful citizen; and be it further

*Resolved*, third, That the sympathy of the members of the Union County Medical Society be extended to the family of Dr. W. G. Fike.

Fourth—That a page upon the minutes of said Society be dedicated to his memory, and that a copy of these resolutions be published in the papers at Union, and in THE JOURNAL of the South Carolina Medical Association; also that

a copy of said resolutions be sent to the immediate family of Dr. W. G. Fike.

C. W. AUSTELL, M. D.,

S. G. SARRATT, M. D.,

M. W. CULP, M. D.,

Committee.

#### OCONEE.

The Oconee County Medical Society met at 1 p. m. on March 2d, 1906, at Seneca, S. C., at the Palmetto Hotel, with the following members present: Drs. J. H. Stribling, President; E. H. Hines, J. W. Bell, C. M. Walker, W. R. Doyle, B. F. Stone, H. E. Rosser, D. L. Smith, Secretary.

Previous minutes read and approved.

Dr. E. A. Hines, Seneca, read an interesting paper on "Bronchopneumonia."

Dr. J. H. Stribling read an article from the *Councilor* on "The Nostrum Evil."

Dr. W. R. Doyle offered the following resolution:

*Resolved*, That no member of the Oconee County Medical Society make an examination for any old line insurance companies for a fee less than \$5.00.

*Resolved*, That the Secretary notify all members that are not present to-day, by card.

Dr. Rosser moved that each member of the Society furnish the Secretary with a list of their delinquent "Dead Beats" every six months, and he to make up a list and send out to each member.

After discussion, Dr. Stone moved that a committee of three be appointed to devise some plan and report at our next meeting.

The following members were appointed to prepare papers for our next meeting, at Westminster, on April 11th: Drs. H. E. Rosser, McCutchen. Dr. W. H. Nardin, Jr., of Anderson, is invited to deliver a paper at the same time.

D. L. SMITH, M. D., Sec.

#### CORRESPONDENCE.

##### PRIORITY OF DR. BAKER'S OPERATION FOR PUS TUBES.

Washington, D. C., March 10, 1906.

To the Editor:

DEAR SIR:—

I have read with much pleasure the excellent paper by Dr. A. E. Baker on "Pus Tubes" in THE JOURNAL of November 21, 1905. The paper in every respect is admirable and we have no criticism to make of the paper itself, for it is a model of terse statement and correct and practical teaching. But the admirable technique which Dr. Baker calls "his method" has been used by many surgeons for years past. The writer has the unchallenged honor of having introduced practically the same plan of removing pus tubes more than ten years ago. See a paper in Trans. Amer. Med.

Assn. held at Atlanta, Ga., Section on Diseases of Women. Title, "How to Remove Pus Tubes Without Rupture."

Yours very truly,  
I. S. STONE, M. D.,  
Surgeon to Columbia Hospital.

## NOTES AND REVIEWS.

### Practice of Medicine and Clinical Medicine.

JOHN L. DAWSON, M. D.

#### DIET IN TYPHOID.

Claytor's treatment of a case of typhoid fever, no matter on what day of the disease it may come under his care, is as follows: The regulation six ounces of milk are given every two hours, night and day, while the patient is awake. In place of milk, in order to vary the monotony for those who can take milk, and as a substitute for those who can not, animal broths are given. After the subsidence of the more acute symptoms the patient is asked if he is hungry, and if he replies in the affirmative a soft-boiled or poached egg is allowed, and if well borne the number is gradually increased to three or more a day. Jelly or blanc mange, custard, soft toast, the soft part of a baked apple, and rice which has been boiled four hours, are the next additions. After this scraped beef or chop, very finely divided chicken, and baked potato are tried. Claytor does not advocate so full a diet in every case, for each patient must be carefully studied as an individual. He believes that most of the foods mentioned are quite as digestible, far more palatable, and rather less likely to cause perforation or hemorrhage by their local action, or gas production, than milk.—T. A. Claytor, Washington, D. C. *Medical Record*, N. Y., March, 17.

#### CAUSE OF EPILEPSY.

Lerch advances the theory that the basis of epilepsy is a diseased brain, congenital or acquired. The widely accepted theory of auto-intoxication he considers, with the rest of etiologic factors, as a remote cause producing congestion and edema. He thinks that the large number of patients in whom a neuropathic constitution and epilepsy can be traced directly, and the large variety of lesions that are found in the epileptic brain favor the correctness of his theory. He says that the same train of symptoms, occurring under the most varied conditions, in patients of all ages, uninfluenced by sex, climate and disease, calls for one direct cause to produce the attack. This cause is congestion and edema.—O. Lerch, *American Medicine*, Philadelphia, March 3d.

#### TREATMENT OF DIPHTHERIA.

Rhodes believes that the very slightest excuse should be sufficient for the diagnosis of diphtheria in a child. Even so slight a sign as dryness or a parched appearance of the external nares in a child who seems poorly nourished is sufficient to indicate, in most cases, that diphtheria toxin is being manufactured, probably in the nasopharynx. He holds that diphtheria antitoxin never does any harm to a child and that it will assist in curing illness due to some disturbance in the throat or nasopharynx, even if that illness is not actually due to diphtheria. The time lost by delay in giving antitoxin in

diphtheria is often sufficient to render the chance of recovery very small. Rhodes states that, though many experienced workers in the field of infectious diseases insist that very large doses are much more efficacious than small ones, sufficient stress is not laid on the fact that small doses, even though given late in the disease, will often just turn the scale in favor of the patient, or at least assist the patient to fight the disease and to hold it in check until the child can be taken to a hospital, where more antitoxin can be given. Finally, if every general practitioner would carry a syringe and one phial of antitoxin much more antitoxin would be given before the child is removed to hospital; the necessary delay in getting the antitoxin at present, and the difficulty, sometimes, in obtaining it, especially in country districts, being possible reasons why this treatment is not adopted immediately in all cases.—T. B. Rhodes, *Brit. Med. Journal*, Feb. 17th.

#### THE LATEST VIEWS OF TYPHOID INFECTION.

Kutscher reviews the recent evidence which shows that persons may harbor the typhoid bacilli in their bodies for years after an attack of typhoid fever and thus prove a source of contagion for others at any time. The bacilli seem to lurk in the gall bladder after they have vanished from all other points in the body. No means have yet been discovered of annihilating the lurking bacilli. Women seem to predominate among these chronic "bacilli-bearers." Contact infection is assuming more and more importance, and the principles of successful prophylaxis must be the same as for cholera and malaria. The chronic bacilli-bearers should be excluded from such occupations as are liable to spread infection, especially in dairies.—"Kutscher," *Berliner Klinische Wochenschrift. Epidemiologie der Abdominal Typhus*.

### MATERIA MEDICA AND THERAPEUTICS.

J. L. NAPIER, M. D.

#### SPARTEINE—ITS DOSAGE, PHYSIOLOGICAL EFFECTS, AND THERAPEUTIC USE.

Petty writes an article on this subject in the *Georgia Practitioner* for November, 1905. He asserts that sparteine is one of the most valuable remedies in our Pharmacopœia, but it is comparatively unknown to the profession. Not only are its properties not generally known, but its dosage is so completely misunderstood that there is little chance for them to become known. It is a remedy of great value, because it does most perfectly what no other remedy or combination of remedies does, and while doing that it does not have other effects which are undesirable. In other words, we can depend upon sparteine to make one important therapeutic impression without its making other impressions that we do not want made.

Sparteine is the alkaloid derived from *Cytisus Scoparius*, our common broomcorn. Since the misunderstanding as to its dosage is doubtless the reason that it is not in common use, the author calls attention to that part of his subject first. Most of the authorities give the dose of sparteine as from 1/6 to 1/3 grain. The U. S. Pharmacopœia, just issued, states the dose to be 1/5 grain, but the manufacturers of hypodermic



tablets make no tablet larger than  $1/10$  of a grain, and few of them list a tablet larger than  $1/30$  of a grain. Hypodermic tablets of these sizes are the form in which it has usually been tried; but many practical men, after trial of the drug in these quantities, and being unable to develop the desired effects, have thrown it aside as of no value, when had the proper dose been given the result would have been otherwise. The fault was not with the remedy, but with the size of the dose.

Bartholomew is the only author, of those whose writings the writer has examined, who states the dose at anything near the proper quantity. He puts it at from  $1/2$  to 2 grains, but from  $1 1/2$  to 2 grains would be more nearly correct. In fact, 2 grains, by the stomach, is as small a dose as can be depended upon. One and one-half grains hypodermically is a fairly effective dose, but there is no reason why the hypodermic dose should not be 2 grains also. It is a non-toxic drug, as truly so as quinine; it is as certain and definite in its effects as quinine; and in the writer's experience it above all other remedies deserves to be classed as a heart tonic. It does just what we want done when we administer a heart tonic, without doing what we do not want done. It combines the desirable effects of digitalis and veratrum without their undesirable effects. Since physicians are so familiar with these two remedies, the author compares the effects of sparteine with them.

Digitalis is a true heart tonic so far as its effect on the heart itself is concerned; but, while it adds tone to that organ and lessens the frequency and increases the force of its action, it powerfully contracts the entire arterial system and greatly raises blood pressure, thus increasing the resistance to the onward flow of the blood current. So marked is this effect that it is probable that it adds to the work of the heart as much as it increases its strength; therefore as a heart tonic it is comparatively useless.

Veratrum, on the other hand, reduces the force and frequency of the heart's action, and at the same time dilates the arterial system, thus reducing the blood pressure and opening up the way for the onward flow of the blood current; but this action is attended by great depression, nausea, and other undesirable effects. If we could develop the effects of digitalis on the heart muscle accompanied by the effects of veratrum on the arterial system, without any of the other effects of these two remedies, we would have the ideal heart tonic. In sparteine we have a remedy that does this very thing. It adds to the tone of the heart muscle as greatly as digitalis, reduces the frequency and increases the force of the heart action as does digitalis, but instead of contracting the arterial system and raising blood pressure as digitalis does, it has directly the opposite effect. While it does not dilate the arterial system so greatly as veratrum does, it does so to a marked degree, but without any of the unpleasant effects of that drug. Especially marked is its effects upon the arterial capillaries; in this respect it resembles belladonna; however, its effects are not confined to the superficial capillaries, as in the case of belladonna, but extend to the deeper capillaries as well. Under its influence the pulse is soft, full, and compressible, instead of hard and unyielding as from digitalis. Its action is prompt. If given hypodermically its effects are well established within an hour, being

in that respect very unlike digitalis, but in point of duration of effect it is again like digitalis, the effect lasting from six to twelve hours. In fact, it has almost the promptness of strychnia with the sustained effect of digitalis.

In the matter of correcting irregularities of heart action it should be given first place. It corrects these with great promptness, and the sustained effect of the drug makes its frequent administration unnecessary. An initial dose of two grains should be given, and it should be repeated in two or three hours. After that it need not be administered oftener than every four to six hours.

While sparteine is a remedy of the greatest value in all conditions that demand regulation or support of the heart, it is in pneumonia particularly that it fills a place that no other remedy or combination of remedies fills equally well. In that disease we have an overworked heart, high blood pressure, pulmonary and general venous congestion, and death usually results from failure of oxygenation of the blood due to exhaustion of the heart. Sparteine counteracts the development of this condition more perfectly, and does more to correct it after it has developed, than any other drug of which the author knows. It decreases the frequency and increases the force of the heart action, imparting a reliable degree of tone to the heart muscle. At the same time, by dilating the arterial system and reducing blood pressure, it relieves the heart of its burden, thus enabling it to handle the volume of blood without laboring, and to throw an ample current to the lungs, where the improved capillary circulation which it produces promotes abundant oxygenation. It does this without a single unpleasant, undesirable, or hurtful effect; in fact, the only other effect of the drug is one that, in pneumonia, is needed almost as badly as the one just described. Its power to improve the arterial capillary circulation renders it a most certain and efficient, non-irritating diuretic. All will recognize this as a most desirable effect.—*Exchange*.

#### BITTERS AS AN AID TO DIGESTION.

It has been found that bitters do not of themselves increase the flow of gastric juice, but now it appears that they do act in that manner if food is taken immediately after their ingestion. This has been demonstrated experimentally in the case of the dog by Straschenko, and his findings have been confirmed. Thus it is evident that the simple omission, in previous experiments, to give food after the bitters vitiated the value of the investigation. All this is set forth in a communication recently read at a meeting of the Hospital Medical Society of Paris, the work of J. Nano and F. Nironesco, of Bucharest, presented by M. Rogers (*Bulletins et mémoire de la Société médicale des hôpitaux de Paris*, Nov. 23).

The Bucharest experimenters add an interesting observation of their own. It is to the effect that the bitters which they employed on the human subject, for the most part tincture of cinchona, not only produced a decided increase in the flow of gastric juice when their administration was followed by feeding, but also gave rise to a notable augmentation of the amount of hydrochloric acid in the secretion. Therefore we may conclude that in the particular form of gastric inadequacy termed hypochlorhydria bitters serve a most important purpose, and we may further in-

fer in general that their use, long sanctioned by experience, now rests upon the solid foundation of laboratory investigation.—*New York Medical Journal*, Dec. 16, 1905.

#### THE RATIONAL USE OF INFANTS' FOODS.

In the course of an article bearing this title, and published in the *Clinical Journal* of November 22, 1905, Sutherland, after pointing out the evils of these foods, says that apart from actual illness there are times when fresh cow's milk is not obtainable, as on board ship or on a long railway journey. Again, fresh milk may be obtainable, but there may be an epidemic in the neighborhood, and the milk supply may have fallen under suspicion. In such cases the physician will be called on to advise, and condensed milk of a good brand is probably the best temporary substitute for a healthy infant.

In all cases in which these more or less unnatural foods are being used certain rules of procedure ought to be followed as safeguards both of the infant's health and the doctor's reputation.

1. In acute illness a return to natural feeding should be made before the patient is discharged.

2. In chronic illness no "infants' food" should be continued longer than is absolutely necessary. If the infant is apparently thriving well on the food, it will in all probability actually thrive better on a fresh milk diet.

3. In all cases in which a predigested or preserved food has been used for more than two weeks, orange or grape juice (half an ounce) in water should be given daily to avoid the risk of scurvy.

4. Under similar circumstances the addition of fresh cream or cod-liver oil to the diet should be made as soon as possible, because the fatty element is usually deficient in all "infants' foods" (as prepared for use), and is specially essential.—*Exchange*.

### OBSTETRICS AND DISEASES OF CHILDREN.

LANE MULLALLY, M. D.

What is the Best Method of Treating Uterine Inertia? (*Therapeutic Gazette*, February.)

Grandin advocates prophylaxis and recommends for those women who lack nerve tone, strychnine grs. 1-60 and quinine gr. 1, three times a day during the last months of pregnancy.

When the child has been delivered, he does not immediately proceed to deliver the placenta, but waits until the uterus has recovered its tone. If no other causes present themselves, he packs the uterus well with gauze, and states that as a rule, when the gauze is removed, within thirty hours, the uterus contracts.

Jewett does nothing for simple inertia when the patient can sleep and eat and the membranes are intact.

When indications for prompt delivery appear, he uses hot and cold compresses over abdomen, alternating one with the other. He recommends quinine in 5 to 10 grain doses, or else strychnine gr. 1-30 every four hours.

For inertia occurring during the second stage of labor his treatment is the same as for the first stage. He recommends forceps for inertia occurring after full dilatation of os.

Polak gives morphine gr.  $\frac{1}{4}$ , atropine gr. 1-150, and packs the vagina with gauze if the membranes are unruptured and inertia comes on.

Polak recommends strychnine grs. 1-30 every half hour until 1-5 gr. is taken, provided the pains have been strong, and then gradually diminish in force and frequency.

For inertia following the third stage of labor, he recommends ergot friction and uterine tampon.

Manton recommends for simple inertia quinine, strychnine and strong, black coffee.

E. P. Davis (*American Journal of Obstetrics*), in an article entitled "Appendicitis Complicating Pregnancy and Parturition," reports six cases as typical of various phases of the subject. He quotes Treves as saying that it is impossible to distinguish clinically between chronic appendicitis and chronic ovaritis.

Davis also quotes from Heaton, who says that mild attacks of appendicitis may not interfere with pregnancy in the early months, but if suppuration occurs danger is enormously increased and pregnancy almost invariably interrupted. In those mild cases when the inflammatory process has apparently subsided, after labor or miscarriage, pelvic inflammation of the right side may develop, which frequently goes on to suppuration, and in these cases it is impossible to tell without operation whether the Fallopian tube or the appendix is the cause of the trouble. Appendicitis may occur at any time during pregnancy and may be primary or secondary. The vomiting which accompanies the attack may be mistaken for the vomiting of pregnancy. Appendicitis during pregnancy runs a rapid course; suppuration usually develops, and pus when formed must be evacuated as soon as possible.

While the cases reported by Davis were not cases where the suppuration occurred, still Davis claims they emphasize two points: the good result of operation in early pregnancy in appendicitis, and the fact that where a severe appendicitis has occurred. Whether during pregnancy, or when the patient was not pregnant, it is an important complication in the pregnant condition, for adhesions following appendicitis may bring discomfort and danger to a patient who becomes pregnant after recovery from disease of the appendix.

Davis concludes his article by urging that the appendix be removed in pregnant women as soon as inflammation attacking that organ can be diagnosed; remembering the impossibility of differentiating between inflammation of the right Fallopian tube and ovary, and inflammation of the appendix complicating pregnancy, operation should be done without waiting to make a positive diagnosis that the tube is inflamed and the appendix not affected, or that the contrary is the case.

### GYNECOLOGY.

C. M. REES, M. D.

In the April number of the *American Journal of Obstetrics and Diseases of Women and Children*, Dr. Wilmer Kousen gives a paper on "Embolism Following Abdominal Section," a subject of importance, to which little attention has been given. The subject selected is simply emboli following celiotomy. In a review by Dearborn



(Annals of Gynecology and Pediatrics, Nov., 1904) of the work of twenty-five surgeons of Boston and vicinity, it is shown that thrombosis and embolism are more common after operations in the pelvis than after operations in any other part of the body. Further, that it is possible that many cases of pleurisy, pneumonia and pulmonary abscess following operation are due to emboli. Large emboli almost always cause speedy death by syncope or asphyxia; very small emboli usually run a favorable course.

Dearborn says that any sudden increase in pulse rate during convalescence, the temperature remaining almost normal, should remind one of the possibilities of thrombosis, and that if there are evidences of phlebitis or of thrombosis, absolute rest in bed must be insisted on. Agnew observes that "after operations in which much blood had been lost, there is always more or less tendency to the formation of coagula. This may take place in the vessels of the extremities, and by forming an obstruction to the circulation, cause the limb to fall into a state of gangrene. From the same tendency to the coagulation of blood a clot may form in the heart to destroy life. He has seen both these accidents occur. Hence he says it is of the first importance that patients thus predisposed should be kept perfectly quiet and in the recumbent posture. Any considerable effort, such as sitting up in bed, when the power of the heart has been lessened, and the vessels deprived of a large amount of blood by an operation, exposes the individual either to a fatal syncope, or to the formation of obstructive plugs of fibrin." Thrombosis may result: (1) After a prolonged or severe operation; (2) as a result of sepsis in the wound; (3) where neither of the above conditions obtain. If thrombosis due to stagnation of blood occurs, it occurs during the formation of the clot, most commonly about a week or ten days after the operation, though it may take place very much earlier than this, and it may occur as late as the third week.

In a résumé of 7,130 gynecological operations, Schenck reports 48 cases of thrombosis. He points out that this complication is much more common after operations in the pelvis than after operations in any other part of the body.

## LARYNGOLOGY AND RHINOLOGY.

W. PEYRE PORCHER, M. D.

In the *Journal of Laryngology* for March appears an article by C. P. Linhart, of Columbus, Ohio., on "Some Evils of Mouth Breathing." There is no subject so far-reaching as this, nor one that is more frequently overlooked.

In view of the modern germ theory of disease, it is remarkable that the full significance of this condition is not more often dwelt upon and the laity educated up to it. It is difficult to condense this article, because the truth cannot be eliminated without weakening the force of the argument or injuring the substructure. I must therefore reproduce the article to show the importance of it.

"In trying to find the origin of many cases of chronic pharyngitis, my suspicions were attracted to mouth breathing as one of the common causes of this complaint. With scarcely an exception, patients suffering from chronic pharyngitis have

more or less difficulty in inhaling sufficient air through the nose. This is particularly noticeable when exercising briskly out of doors during the cold and damp season of the year. If anyone should take the trouble to observe the people on a cold winter morning as they walk to their places of business he would be surprised at the number who are inhaling the cold, raw air through the open mouth directly into their lungs. The thin and delicate membrane of the pharynx and the larynx is utterly incapable of giving moisture to, and heating the air to its proper condition before entering the lungs. The cold air over-stimulates the vasomotor nerve endings controlling the small capillaries of the throat. There is first a contraction and blanching of the membrane from the cold, followed by a relaxation of the capillary walls, and a pouring out of the secretion from the mucous glands in this region. The work that this membrane is called upon to do is entirely beyond its capabilities, it becomes thinner, the patient complains of a dryness in the throat, and in course of time the result is a chronic pharyngitis.

The question as to the original cause of mouth breathing would seem a little difficult to answer. Very young children, I think, as a rule, have little difficulty in breathing through the nose. It is only in later childhood, subsequent to the hypertrophy of the adenoid tissue in the vault of the pharynx, and hypertrophy of the tonsils, that the children begin to breathe through the mouth.

It seems proper to suggest that our habits of living are such as to bring about these very conditions. In the first place the children are often housed in over-heated and ill-ventilated rooms, and coddled in heavier wraps than is necessary for their health. This hot-house preparation illy prepares them for the vigorous and sudden changes that they undergo in passing from these warm rooms into the winter air. These sudden changes are probably a strong factor in bringing about the congestion of the mucous membrane and underlying tissue of the turbinates in the nose, and increasing the hypertrophy of the glandular tissue in the pharynx.

"Does not the continual tropic house warmth actually reduce the tone of the tissues and make them more susceptible to bacterial invasion? The thought is naturally suggested that perhaps cold air has hygienic as well as therapeutic uses. We rather look upon hot weather as relaxing and destructive of vitality, and expect health with return of cold weather. Brook trout perish if the water they breathe is raised only a few degrees in temperature. There is enough in this matter to cause us to think about it a little. If so many cured tuberculous patients are now sleeping in cold air every night and living in it in the daytime, too, as much as possible, perhaps the rest of us are only injuring ourselves by the opposite course. Only a few years ago the cold-air fiend who slept with windows wide open in the coldest winter, was considered a crank. Perhaps he will prove to have been the only sensible one among us, and was merely imitating the ways of his ancestors who had practically no way of warming their houses."

As it is the function of the turbinates to supply sufficient moisture to the air and properly regulate its temperature as it passes into the lungs, it naturally follows that the air must be made to pass through the nose over the turbinates in order that they may be in proper condition to do their work.

One of the probable evils of mouth breathing in early life, is the raising of the palatine arch by undue pressure from the inhalation of air through the mouth. This excessive arching of the hard palate, which is also the floor of the nose, encroaches upon the space in the nose. During development the septum would naturally grow so as to fill the space allotted to it in the nose. Now that the space, as has been shown, is consequently narrowed in its perpendicular diameter, and it naturally follows that the septum will bend to one side or the other. Where a person has high-arched palate we expect to find either a deflected septum in the shape of a large curve, or a sharp kink or spur. The latter is nearly always seen along the line where the vomer joins the perpendicular plate of the ethmoid.

A popular impression prevails that deflections and spurs of the septum are caused by a blow on the nose some time during development. While it is easy by suggestive questioning to get a history of an injury to the nose, in almost every instance of deflected septum, I usually find that when the patient volunteers the information of a blow on the nose, that the injury has been sufficient to cause considerable thickening of the whole septal wall, from the consequent inflammation, which is not found in ordinary septal deformities.

There is no doubt that mouth breathing, with its consequent high arching of the palate, is responsible for the peculiar shaping of the face seen in many children suffering from adenoids. It is also a factor in causing the protruding and misshapen teeth of the upper jaw. Dr. C. A. Hawley tells me that in looking over twenty-nine plaster casts of corrected deformities of the teeth from narrowing of the upper jaw, he found nineteen with histories of operations for removal of adenoids. These cases were taken at random, and he further states that he had no doubt that some of the others had nasal or post-nasal obstruction. Dr. Hawley called my attention to another interesting point; that a high-arched palate and narrow posterior nares might have the relation to each other of cause and effect.

The secretion of the nose is more or less bactericidal. The dust in the air on entering the nose is filtered through the moistened vibrissae, and also becomes deposited on the viscid membranes of the turbinates, consequently the mouth-breather, lacking this natural protection, is most susceptible to bacterial invasion, and on account of the discomfort and annoyance of breathing through the mouth will not inhale as deeply as he ought. Therefore there is not sufficient oxygenation of the blood and consequent lack of body tone.

There is no doubt that considerable disturbance to digestion is caused by allowing the mucopurulent material from the naso-pharynx to get into the stomach, in fact, it is next to impossible to prevent young children from swallowing it. I had a patient who had been troubled with indigestion for several years, tell me that it entirely disappeared after being relieved of this annoyance from a chronic nasal catarrh. I venture to say that the fermentative changes which take place in the mouth of a mouth-breather, have an injurious effect on the salivary secretions sufficient to interfere materially with the digestion of starchy foods, and this in turn would lessen the stimulative effect on the peptic glands of the stomach.

Breathing through the nose develops the muscles that dilate the nostrils, consequently we find narrow nostrils in mouth-breathers. Furthermore where the obstruction in the nose is confined to one side it naturally follows that the narrow nostril will be on that side.

I have had a number of cases of pharyngeal irritation that I could trace to no other cause than a partially occluded nostril, and it seemed to me that the air volume being so much heavier on one side gave it a corkscrew motion as it passed down the pharynx. This whirling and uneven pressure of the air might cause an irritation of the throat by producing an unusual dryness in one part and too little in another. This would account for the little inspissated lumps of mucous found in this class of cases, in the vault of the pharynx. Of course, one must take into account the fact that so large a volume of air passing in one nostril would not get the heat and moisture that it would from both sides more nearly equal in caliber. Whatever the cause, there is always a marked improvement where the entrance of air through each side of the nose is more evenly balanced.

If we accept the foregoing statements of facts, it is easily understood how the habit of breathing through the mouth is so difficult to overcome, and the importance of keeping a clear passageway in the respiratory tract of children is apparent and it becomes evident that whenever there is any hindrance to normal breathing even from a transient "cold," it should have immediate attention. Any obstructions should be removed by surgical means, and the patient encouraged in his effort to breathe through the nose. Even later in life when the bones of the mouth and nose are completely ossified, the openings of the nares can be enlarged by proper breathing exercises.

The following are recommended for keeping the nose in a normal condition: Cool living rooms, well-ventilated sleeping rooms, cold bath, especially for the neck and spine, dry clothing, simple foods, regular habits, moderate daily exercise and exclusive nasal breathing."

Reference is again made to the desiccating effect of formaldehyde solution upon mucous membranes and its efficacy in rhinorrhea, acute rhinitis and otorrhea. Some persons have even the electric cautery with good effect in an acute rhinitis to reduce the tumescent turbinate but of a simple application of a drug which would not leave a scar tissue behind it would be all the better.

#### DEEP INJECTIONS OF ALCOHOL FOR RELIEF OF NEURALGIA.

Oswalt's communications on this subject have recently reviewed in these columns, page 390. He here reports 45 cases of severe chronic facial neuralgia cured by this simple means. He adds a little of some local anesthetic to the alcohol, and slowly injects it for what he calls the "temporary gasserectomy." After from five to seven days he repeats the injection, if necessary, but once is usually sufficient. He follows Schlosser's technic closely and has found the procedure effectual, even for treatment of certain cases of spasmodic contracture and for sciatica.—*Exchange*.



## OPHTHALMOLOGY AND OTOTOLOGY.

## EXAMINATION OF THE EYES OF PREGNANT AND LYING-IN WOMEN.

EDWARD F. PARKER, M. D.

Examination of the Eyes of Pregnant and Lying-in Women.—Dr. Polte (from the eye clinic in the University of Halle, A. S., *Klin. Mon. fuer Aug.*, 1905, ii, p.

Polte examined with the ophthalmoscope 200 pregnant women and 177 after delivery. Of the former 178 were healthy, 18 had albuminuria and 6 out of these eclampsia, 1 morbus maculosis, 3 pyelitis. As a rule, the fundus was normal in the 178 pregnant, 116 of which were in the last month. Symptoms similar to those in neuritis, as found by Bosse in 75 per cent. of women during gravidity, could never be ascertained. Only in 2 cases a certain white fovea of the disc was observed *postpartum*, which before birth had the same red tint as the remaining portions of the disc. In the third case the borders of the disc, indistinct before delivery, were well defined after it. Only 1 out of the 6 eclamptic cases presented slight ophthalmoscopic changes which had subsided on the first day of the puerperium. Five out of 10 cases of albuminuria with casts had chronic nephritis. Two with albuminuric retinitis are reported in detail. During labor nothing abnormal was observed, excepting slight hyposphagma in 3 cases.

Polte's investigations do not corroborate the assertion of Bosse that ophthalmoscopic changes are frequent during pregnancy.—[C. Z.]—*Exchange*.

## VERNAL CONJUNCTIVITIS IN THE NEGRO.

DUNBAR ROY, M. D.

A study of ten cases of corneal disturbance in the negro has been made, which, in the opinion of the author, were cases of bulbar vernal conjunctivitis. No palpebral lesions existed. There was present at the sclero-corneal margins elevated, circular, waxy and gelatinous looking masses, extending from  $\frac{1}{2}$  to 4 mm. into the cornea. The subjective symptoms were not severe. They all proved very untractable to treatment, and the condition came on every summer and lasted through the warm months. He believes that it is quite possible that the different views expressed upon vernal conjunctivitis are largely due to different aspects of the disease in different localities. An extensive report from Prof. H. F. Harris on his findings from examinations of shavings from the hyperplasias of the cornea of some of the negroes' eyes is given.—[M. B.]—*Exchange*.

## PHOTOGRAPHING THE INTERIOR OF THE EYE.

"An apparatus, by means of which it has become possible to obtain good photographs of the background of the eye has been devised by Dr. Walther Thorner, of the University Eye Clinic in Berlin

This result, though long desired by oculists, has hitherto been found impossible. Dr. Thorner has, however, accomplished this important step in the treatment of eye diseases. His contrivance constitutes a material improvement of the ophthalmoscope invented by Helmholtz in 1850, which latter device only admits of looking at the

background of the eye. Owing to its peculiar construction, it has been impossible heretofore to photograph the interior or back of the eye. It is a matter of great difficulty to illuminate the interior sufficiently to take a serviceable picture, and even if strong sources of light were used the exposure would last too long, rendering necessary a fixation of the eye, which, in turn would entail serious inconvenience to the patient.

"Dr. Thorner first succeeded in obtaining photographs of the eyes of cats, but the interior of the human eye being much darker it required many improvements before good photographs of the interior of human eyes could be taken. The changes proved perfectly satisfactory. With a soft light the eye is first so focused that its back yields a clear image on the photographic plate. The plate put in, the camera itself is opened by pressure on a special lever, and a flashlight composition is ignited by means of an electric spark generated in a storage battery. Thereby the background of the eye is lighted up for a moment sufficiently to produce a good image on the plate.

"It is possible to distinguish healthy eyes readily from the sick ones, the eye of a strongly short-sighted person being, for instance, characterized by a peculiar ring around the sun-like illuminated center. Oculists will now be enabled to watch the progress of eye diseases or disorders step by step. The apparatus also permits of taking a picture of any separate part of the interior of the eye."—[H. V. W.]—*Exchange*.

## RELATION BETWEEN DISEASES OF THE AUDITORY APPARATUS AND THOSE OF THE EYE.

Blanco, T., Valencia (*Archives de Ophthalmologia*, November, 1905).

T. BLANCO, M. D.

Blanco refers to many reported cases of ocular involvement dependent on diseases of the ear and mentions the various explanations of the pathogenesis as given by different authorities. According to the author, these various ocular phenomena are dependent on the intimate connection existing between the trigeminus, facial and the nerves controlling the ocular muscles; in this manner are explained the occasional appearance of reflex affections of both the extrinsic and intrinsic ocular muscles following pain in the auditory apparatus. The paper is very exhaustive and well worthy of perusal in the original. In an appendix is given a résumé of eleven cases from the literature, together with two personal observations.—*Exchange*.

## EYE DISEASES FROM AUTOINTOXICATION.

Elschnig, Wien (*Klin. Mon. fuer Aug.*, 1905, ii, p. 417).

By way of excluding other morbid causes, and, most important, by the therapeutic results, auto-intoxication must be assumed as the cause of many and grave eye diseases. Elschnig studied these conditions within the last 10 years on his private patients and reports aphoristically on his observations, after giving a synopsis over the various forms of auto-intoxication, as intestinal or histogenous auto-intoxication, e. g., diabetes, gout, uremia, carcinoma, chlorosis, gravidity, puerperal state, lactation, etc., or insufficient physiologic

excretion of toxins from diseases of certain organs (thyroid gland, adrenal capsules, liver, hypophysis). The most important symptom of gastrointestinal intoxication is the presence of abnormal organic substances in the urine, e. g., indican. Chiefly the nervous apparatus of the eye, the corneoscera and uvea react to the influence of gastrointestinal autointoxication. Thus in paralysis of the interior or exterior ocular muscles, optic neuritis may occur, with symptoms similar to those in ptomain intoxications (botulism, intoxications by cheese, etc.), or functional disturbances, as neuralgia, scintillating scotoma. In none of the cases of typical relapsing retinitis, iridocyclitis and iritis, excepting a case of gonorrhoeic iritis. Elschnig could find another etiology, and his diagnosis was corroborated by the treatment. Eight cases of recurrent iritis are given in detail. Elschnig considers a connection of relapsing hordeola with gastrointestinal disturbances beyond doubt. An appropriate diet and disinfection of the intestinal canal with carbonate of guaiacol proved very effectual in these cases. The literature is extensively utilized.—[C. Z.]—*Exchange*.

### BOOK REVIEWS.

The Medical Diseases of Infancy and Childhood, with Points on the Anatomy, Physiology, and Hygiene Peculiar to the Developing period, by Alfred Cleveland Cotton, A. M., M. D., Professor of Pediatrics Rush Medical College, Chicago; Attending Physician for Diseases of Children Presbyterian Hospital, etc., etc. J. B. Lippincott Co., Philadelphia and London.

In this work Dr. Cotton has given us a valuable addition to the text-book literature on the diseases of children. An especially good feature is a careful description of the anatomy and physiology of the new-born, with which the book opens. Special attention is, of course, paid to the most important matter of infant feeding, and the directions for modifying milk are full and excellent. An appendix treats of the hygiene of the sick room, massage, hydrotherapy, the internal use of water, etc., and admirable suggestions are given in the section on Dietary and one devoted to useful formularies. The work contains 648 pages and is unusually well illustrated.

Diseases of the Nervous System Resulting from Accident and Injury.—By Pearce Bailey, A. M., M. D., Clinical Lecturer in Neurology, Columbia University, New York City; Consulting Neurologist to the Roosevelt, St. Luke's and Manhattan State Hospitals, etc.

A new and revised edition of the popular work on Accident and Injury and Their Relations to Diseases of the Nervous System, by Pearce Bailey, A. M., M. D., of New York, has just been published by D. Appleton & Co.

The first edition of this work was printed in 1898. The present revision required a recasting of the entire book, therefore the present volume is printed from new plates. It is a thorough revision in every sense of the word, in fact, a new book, and the title given this revision, namely, Diseases of the Nervous System Resulting from Accident and Injury, is believed to be a more correct one than the one used when the book was first published.

A number of new illustrations have been added and many old ones have been displaced by new.

Dr. Bailey is an authority upon the subject covered in his book, especially upon medicolegal questions.

The author says in his preface, "Those subjects most fully described in text-books on surgery are dismissed with briefest mention. The late effects of brain injuries, for example, receive more notice than the acute symptoms." For this reason the book is of the greatest interest, not only to the surgeon and neurologist but to the general practitioner.

This is a very complete work upon a most important subject, especially to those physicians who are associated in a surgical line with the large corporations, as it treats in a practical manner, of the conditions affecting the nervous system which arises from injuries.

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A Compend of Obstetrics especially adapted to the use of Medical Students and Physicians.—By Henry G. Landis, M. D., late Professor of Obstetrics and Diseases of Women in Starling Medical College.

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The work is illustrated with cuts upon various subjects, and has nicely depicted demonstrations of the application of Forceps and the performance of Podalic Version.

Price \$1.00. P. Blakiston's Son & Co., publishers.

#### MISCELLANY.

#### PASSENGER CARS ALMOST FREE OF BACILLI, SAYS RAILROAD CHEMIST.

In a paper read before the American Public Health Association in Boston, Dr. Charles B. Dudley, chemist of the Pennsylvania Railroad, declares that the danger of contracting tuberculosis in either sleeping or day cars has been greatly exagger-

ated. The upholstery of cars has often been denounced as a promoter of the spread of tuberculosis, it being claimed that the germs find lodgment therein, and eventually are set floating in the air in the form of dust.

Dr. Dudley claims that as a general rule "prolonged exposure" is necessary to infection. The sputum is difficult to dry, and when dry, difficult to pulverize, and even if dry and pulverized is so heavy that it falls to the ground. Continuing, Dr. Dudley refers to the sterilizing qualities of sunlight. He shows from the census that railroad employees suffer far less from consumption than the average of the community. The records of the Pennsylvania Relief Fund show that freight conductors and brakemen are more subject to tuberculosis than are passenger conductors and brakemen.

Dr. J. J. Kinyoun, in the *New York Medical News*, writing of the bacterial content of the passenger car, said that in fourteen examinations of dust from the carpets of cars, many of which were known to have carried tuberculous people, none showed the presence of tubercle bacilli. Out of 64 examinations of dust collected by swabs from the interior surfaces of cars only one might have been bacillus tuberculosis, and this was doubtful; out of 96 examinations of air from similar cars, only one, and out of twenty drinking cups, none.

To inform himself as to the relative danger of textile fabrics and smooth surfaces, Dr. Dudley made experiments with pieces of plush, carpet and glass, putting equal quantities of salted paste on the different specimens, allowing them to dry and then passing over them a heavy iron roller to simulate the conditions of grinding up tuberculosis sputum under the foot. After driving away as much as possible of the pulverized material by compressed air, he found that on the glass about one-third of the material remained, while on the plush and carpet seven-eighths of it stayed behind, indicating that the danger of infection from upholstery fabrics is much less than from naked surfaces.

As the result of a protest made by a committee of the General Managers' Association of Texas Railroads, the Texas State Board of Health has agreed to modify its

rules governing the disinfection of passenger cars. The rule requiring one cuspidor in a car for each seat or every two chairs will be modified so that the cuspidors shall be used only when demanded by a passenger. A supply of them will be carried in each car, and they will be furnished to passengers on request. The rule requiring the use of a disinfecting solution in cuspidors has been abolished, but the cuspidors *must* be kept clean. The railroads have agreed to pay the expenses of sanitary inspectors to see that passenger cars are kept clean.—*Journal of The Outdoor Life*.

### THE FLY AND THE TUBERCLE BACILLUS.

The recent stress which has been laid on alimentary infection in tuberculosis should lead to a more careful consideration of the means by which tubercle bacilli may reach the alimentary canal. The recent studies of Lord show that the ubiquitous fly may play an important part in alimentary transmission. The bacilli not only pass the alimentary canal of the fly unchanged, but undergo a marked proliferation there. Fly specks may contain as many as 5,000 bacilli, and, according to Lord's computations, thirty infected flies may deposit within three days from 6,000,000 to 10,000,000 tubercle bacilli. The danger does not seem to be from the liberation of tubercle bacilli in the air, but from the deposition of the fly specks on food. That this can and does occur under certain circumstances was abundantly demonstrated by our experience with typhoid fever during the Spanish-American war. We should bear in mind the possibility of infection by the fly and be much more strict than we are at present in the disposition of sputum and in the protection of food stuffs, and this refers particularly to the summer months.—*Jour. A. M. A.*

### AGREEMENT REGARDING INSURANCE EXAMINATIONS.

The following agreement has been signed by all the physicians in Burleigh and Kidder counties and copies sent, for signatures, to the physicians in the other counties in the Sixth Judicial District:

"The undersigned physicians, registered and practicing in the Sixth Councilor District, North Dakota, believing that the duties of Insurance Medical Examiners require a high degree of professional skill, absolute integrity and special attention to the interests of the Insurance Companies, do hereby pledge themselves to exercise skill and care in all examinations and to make no discrimination in examinations or fees to different companies. They further agree to be governed by the following schedule of fees:

"Five dollars for each ordinary examination, including urinalysis.

"Ten dollars for each examination where microscopic examination of urine, sputum or other secretion is required.

"Three dollars for each certificate of health for renewal of lapsed policy."—*The Councilor's Bulletin*.

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R. Kirksey.....	Pickens.
W. M. Long.....	Liberty.
L. O. Mauldin.....	Pickens.
L. F. Robinson.....	Dacusville.
J. O. Rosamond.....	Easley.
H. E. Russell.....	Easley.
W. A. Sheldon.....	Pickens.
W. A. Tripp.....	Easley.
E. B. Webb.....	Liberty.
C. N. Wyatt.....	Easley.

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J. H. Taylor.....	Columbia.
J. L. Thompson.....	Columbia.
E. J. Wannamaker.....	Columbia.
J. J. Watson.....	Columbia.
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	[R. F. D. No. 5.
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A. C. Smith.....	Glenn Springs.
W. A. Smith.....	Glendale.
H. B. Tate.....	Pacolet.
George Thompson.....	Inman, R. F. D.
John O. Vernon.....	Welford.
Lee J. Wall.....	Spartanburg.
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J. F. Williams.....	Roebuck.
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(SUMTER COUNTY MEDICAL SOCIETY.)

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J. J. Bossard.....	Sumter.
Walter Cheyne.....	Sumter.
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H. T. Hames.....	Jonesville.
J. H. Hamilton.....	Union.
O. L. P. Jackson.....	Union.
J. T. Jeter.....	Santuc.
J. M. Lawson.....	Union.
Theo. Maddox.....	Union.
D. H. Montgomery.....	Union.
S. G. Sarratt.....	Union.

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L. J. Wood.....	Kelton.

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(WILLIAMSBURG COUNTY MEDICAL SOCIETY.)

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J. D. Whitehead.....	Lake City.

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J. J. Campbell.....	Clover.
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T. R. Carothers.....	Rock Hill.
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T. N. Dulin.....	Clover.
W. W. Fennell.....	Rock Hill.
W. A. Hood.....	Hickory Grove.
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W. M. Love.....	McConnellsville.
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J. D. McDowell.....	Yorkville.
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J. R. Miller.....	Rock Hill.
E. W. Pressley.....	Clover.
J. H. Saye.....	Sharon.
W. G. Stevens.....	Rock Hill.
M. J. Walker.....	Yorkville.
T. S. R. Ward.....	Hickory Grove.
W. G. White.....	Yorkville.

## HONORARY FELLOWS.

1870.....	F. L. Parker.....	Charleston.
1871.....	T. G. Simons.....	Charleston.
1872.....	J. C. Spann.....	Catchall.
1873.....	A. A. Moore.....	Camden.
1873.....	M. G. Salley.....	Pinewood.
1873.....	R. L. Brodie.....	Charleston.
1874.....	W. H. Nardin.....	Anderson.
1874.....	J. F. Pearce.....	Claussens.
1874.....	O. B. Mayer.....	Newberry.
1875.....	T. G. Croft.....	Aiken.
1875.....	Manning Simons.....	Charleston.

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Dr. Joseph Price.....	Philadelphia, Pa.
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Dr. George Ben Johnston.....	Richmond, Va.
Dr. James P. Tuttle.....	New York, N. Y.
Prof. J. H. Musser.....	Philadelphia, Pa.

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Bamberg.	Darlington.
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Berkeley.	Lancaster.
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For further information, apply to

**Dr. F. L. PARKER, Dean,**

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**CHARLESTON. S. C.**

An election will be held in  
Charleston, S. C., by the Board of  
Trustees and Faculty of the Med-  
ical College of the State of South  
Carolina on June 15, 1906, to fill  
the Chair of Anatomy.

All applications must be sent in  
to Joseph R. Robertson, Secre-  
tary of the Board.

**JOSEPH R. ROBERTSON,**

Secretary of Board



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## South Carolina Medical Association.

Next Annual Meeting at Bennettsville, S. C.,  
April 17th, 1907.

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# THE JOURNAL

OF THE

## SOUTH CAROLINA MEDICAL ASSOCIATION.

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GREENVILLE, S. C.

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J. W. JERVEY,

Editor.

WALTER CHEYNE,

Associate Editor.

C. B. EARLE, Managing Editor.

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ANNUAL SUBSCRIPTION, \$2.00.

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THE JOURNAL is published monthly under the auspices of the South Carolina Medical Association. Members who do not receive their copies will please notify the Managing Editor at once. Secretaries of county societies are requested to send reports of their meetings, and items of news that may be of interest to the profession. Original articles are solicited. Articles should be type-written; and illustrations sent with articles will be printed at the expense of the writer. Reprints will be furnished at the rate of 75c. a page for a hundred copies.

All matter must be in the hands of the editor by the 10th of each month.

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### EDITORIAL COMMENT.

---

#### OUR NEW PRESIDENT.

---

The elevation of Dr. T. P. Whaley, of Charleston, to the Presidency of the State Association, was a graceful and fitting acknowledgment of the arduous work he has performed as Secretary for the past ten years. The merit system is good, and it is well to see honors go to one whose labor and loyalty has ever been at the command of the Association. The selection was a happy one. The duties of the high office will be discharged with that grace and ability for which our new President is well known among his colleagues throughout the State.

---

#### COMPLIMENTS AND REGRETS.

---

With this issue of the Journal, the original editorial staff retires and a new

corps takes hold. Much has been accomplished, and, thanks to the untiring efforts and excellent management of the editorial founders, the Journal is an accredited success. The circulation is very close to one thousand copies, and, as has been remarked by a post office official who inspects the mailing list, "it goes even to every cross-road and hog path in South Carolina." No better testimonial of its penetrating powers could have been given. There is no Journal published which can even remotely compare with this for reaching the profession of the State. Ethical advertisers are finding this out.

The profession at large throughout the State has regretted that personal reasons impelled the former Editors to withdraw from active management. These gentlemen, however, have assured us that their interest will be maintained, and their assistance lent in every reasonable way.

As for the new staff, we know full well the difficulties which lie before us. Yet, being difficulties, they are but opportunities. We are treading new paths, leading into blooming fields as beautiful as they are new to us. Time will show whether we shall have tilled the fields and gathered the garlands and bouquets they can be made to bear, or whether in idleness and incapability, we shall have suffered them to go to weed and empty fallowness.

To each individual member of the State Association we say:

Remember, this is your Journal, take a personal interest in it. Read it. Talk it up. Pat in on the back when it merits it, and when you think criticism needed, send it along, straight to the Editor, with suggestions or complaint. Above all, give it a square deal, even as you yourself want the same; and may this particular product of the Golden Rule then prove ever a layer for you all of the golden eggs of fame and fortune.



STATE BOARD OF MEDICAL EXAMINERS.

---

Recent developments in the administration of the State Board of Medical examiners have stirred so much comment throughout the profession of the whole State that it is impossible to ignore it.

It seems to be unfortunately true that a recent examination paper was prepared and presented to several applicants on the initial and sole responsibility of one member of the board. The remaining members had never seen, and, therefore, of course, had never approved this particular set of questions. It is alleged, and we think sincerely and with good cause, that this examination was far-reaching and hyper-technical, and was neither reasonable nor practical.

We do not know whether or not there is any rule in the State Board of Examiners' *modus operandi* requiring the general supervision of the whole board over each individual member's set of questions before being submitted to applicants for certificates of qualification. We are convinced, however, that there ought to be some such regulation, no less in justice to applicants than in justice to the Board itself. It is to be remembered that every set of examining questions is supposed to emanate from the State Board of Medical Examiners, and these gentlemen, as a Board, are responsible to the State Association for every official act of each one of its members. It follows, then, that as a matter of self-protection, the whole Board should supervise every official act contemplated, and before it is publicly executed.

It will not be desirable to have coming young men desirous of entering the profession think that the State Board is merely a stumbling block to catch questions designed to keep them outside the pale, any more than it would be well to create the impression that the Board is a mere formality, requiring no special prep-

aration but a little judiciously exercised "pull."

Either of such impressions would be essentially false, and if widely believed would work inestimable harm, not alone to the Board, but to the entire profession of the State.

The State Board is a tremendously important institution. On it are some of the most conservative and judicious members of the Medical faculty of the State, and they will protect themselves and the whole profession, we are assured, from anything which might even have the appearance of bringing discredit upon their often difficult and delicate positions, or upon the membership of the Association.

---

THE FIVE DOLLAR FEE.

---

While several matters of more than usual interest and importance came up for discussion in the sessions of the Annual meeting, the paramount issue was unquestionably the regulation of fees for life insurance examinations. Compromise resolutions, printed elsewhere in this issue, were adopted, though it is our opinion that the situation is thereby rendered hardly less tense than before. There is no doubt that the very large majority of the Association membership is absolutely in favor of the five dollar fee. It is certainly the veriest tommy-rot and nonsense to say that the big insurance companies cannot afford to pay this amount for a reliable examination. Such high class companies as the New England Mutual of Boston, and other conservative and smaller old liners pay a straight five dollar fee, and will continue to do so. If the profession will stand together as a unit in demanding the higher rate there can be, of course, no doubt that the big companies will either have to pay or withdraw from the field. It is pounds to penny whistles they will not withdraw.

It is seldom that a lay journal elucidates a professional subject. The following from the Charleston News and Courier, however, is so much to the point that we take pleasure in reproducing it:

*Five Dollars Little Enough.*

The resentment on the part of the members of the South Carolina Medical Association against the attempts of life insurance companies to reduce the fee for physical examinations of applicants for insurance will have the sympathy, we think, of the laity. If the physical examination be of any value, it ought to be made by a responsible physician in a careful manner and a fee of five dollars does not impress one as disproportionate to the service required. Lawyers of good repute, if we are correctly informed, do not recognize any consultation fee of less than five dollars, and the medical examination is perhaps the most important step necessary in the negotiation of an insurance contract.

It should be remembered that the physician has no voice as to the volume of his fees. He can do nothing to increase or decrease their number. If the company places an efficient solicitor in the territory the physician benefits and if the company neglects the territory he suffers. If the insurance companies would employ physicians at salaries, offering them a definite contract for reasonable periods, they would probably save money in the examinations. A physician if guaranteed a salary for a year would be willing, no doubt, to make such a number of examinations as would greatly reduce the average fees, but if the present system is to continue members of the medical faculty of good standing cannot be expected to take the responsibility of passing upon one of these examinations for less than five dollars.

As a matter of fact, we do not believe that the insurance companies could save money by employing physicians on salary to make examinations. Nor is it likely that reputable and trustworthy physicians could be secured to do such work in the face of the stand taken by the profession of the State. We take it that no high-minded practitioner could afford, even for a salary of five or ten thousand dollars a year, and in an office of especially uncertain tenure, to make of himself an ethical outlaw in the profession.

THE ANNUAL MEETING OF 1906.

The annual meeting in Columbia in April was a success. The local profes-

sion entertained the visitors informally and delightfully, and we think the elimination of the customary set and formal banquet, with slow courses and slower speeches, was a good plan. Trolley rides, smokers, receptions, private entertainments, and the general commingling of confrères provided sufficient social diversion. In point of numbers there was quite as large an attendance or even larger, perhaps, than last year's session in Greenville, which was itself a record-breaker. Altogether there were over three hundred at the Columbia meeting. The program was unusually short, but some striking papers were presented. This is a feature of the annual meeting, which must be carefully worked up. The number of papers presented may be taken as a fair index of the amount of individual work and research being carried on by members. By all means let us have more of them.

NEGROES AND MALARIA.

In a recent article\* Arthur I. Kendall, Ph. D., Acting Chief of the Board of Health Laboratory of the Isthmian Canal Commission, speaks of the "relative immunity in negroes to malarial infection." He attributes this to their "thick skin and pungent odor" being unattractive to mosquitoes. Doubtless there are a good many practitioners in this State who will emphatically deny that there is any kind of immunity, either relative or absolute, to this disease in the negro race.

The author's attempted explanation of this alleged immunity appears to us somewhat strained and unscientific. In white individuals of varying ages and habitual environment there is probably quite as much difference in skin thickness as there is between that of the average white and the average negro.

\*Jour. A. M. A., April 28th, 1906.



As for the alleged personal repulsiveness to the mosquito of the malodorous Senegambian, we can only say: "Well, *chaque mosquito à son gout*," and breathe an admiring sigh for Madame Stegomias's nice discrimination. It may be that the mosquito has an olfactory development sufficient to make such a reasonably coarse distinction; but if, as Prof. Kendall says, he finds it hard to make the insect take hold of a negro even when facilitated and urged to do so, might it not just as easily and properly be ascribed to some bio-chemical antipathy, as to an offended patch of Stegomyia Schreiderian membrane? Besides, it is well known that the negroes have neither the providence nor the opportunity to flee from miasmatic localities and seasons, and is it unreasonable to suppose that even if a relative immunity does exist, it might be due to acquirement through generations of exposure and infection rather than to a specific immunity?

---

#### VACCINATION—ANTITOXINATION.

---

It is rather curious that in the fight against infectious diseases in the human being vaccination in the true sense has been used but little, aside from its use as a preventive of smallpox. In the sense meant by Jenner and Pasteur, vaccination refers to inoculation with a living organism of attenuated virulence, and it seems desirable in the interest of lucidity that the term should be so restricted and should not be employed to designate forms of protective inoculation in which killed organisms or their extracts are employed.  
—*Jour. A. M. A.*

Jenner and Pasteur probably meant no such generalization as the *Journal A. M. A.* imputes to them. Vaccination, in connection with preventive or protective inoculation, can be properly used only as referring to such inoculations as may be obtained through the medium of animals of the vaccine variety—Latin, *vacca*, meaning a cow. That the virtue of these inoculations lies in living organisms of attenuated virulence is still merely a theory, though amply supported, it is true by powerful circumstantial evidence.

The anti-diphtheric inoculation as an illustration of the correct use of derivatives, might be spoken of as equination, as it is obtained through the medium of animals of the equine variety—Latin, *equus*, a horse. However, we have never heard the term used.

If one word is absolutely essential to science to express the process of preventive or eliminative or antithetic inoculation, the word antitoxination would seem to be sufficient to cover the case generally, whether the attenuated virus or killed organisms or their extracts or anti-bodies be used. An infection is a poison, and anything to combat the poison is, in general terms, an antitoxin. If the inoculation is administered for immunizing purposes and before infection has taken place we might designate it as anti-toxination; if for purposes of destroying and eliminating an infection already existing, we could speak of the method as de-toxination. So let it be.

---

#### NOTES AND COMMENTS.

---

If there is one body whose records and functions should be kept and administered in systematic order, that one would seem to us to be the State Board of Health.

Curiously enough, however, at the recent meeting of the Association none of the members who were present could tell how long the present Board had been in commission, or when its term expired or would expire. The fact is, we are informed that the youngest member of the Board has served eight years, and as the statute fixes the term at seven years, it is clear that a new Board should have been nominated. The old Board will continue to serve, under the law, until their successors are qualified. The matter should receive thoughtful attention at the next annual meeting.

In the retirement of Dr Davis Furman from the State Board of Medical Examiners the Board loses one of its most conservative, able and thorough-going members. Always practical and reasonable; never flighty or dogmatic; and a genuine lover of a square-deal, first, last and all the time, he is a wholesome addition to any body of men with whom his lot may be cast.

---

The Annual Oration, delivered this year by Dr. Paul B. Barringer, of Charlottesville, Virginia, was one of the conspicuously interesting features of the Columbia Meeting. There was a large audience present, including many laymen, who certainly profited by this able—popular science, we might call it—lecture on the “Drugs that Enslave.” Dr. Barringer is a man of big intellect and broad cultivation, and his address was a gem of wide research and studied contemplation. It will be read with interest and profit.

---

## ORIGINAL ARTICLES.

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### ADDRESS OF THE PRESIDENT.

---

DAVIS FURMAN, M. D., GREENVILLE, S. C.

I sincerely thank the South Carolina Medical Association for the honor conferred by placing me upon the list of your distinguished Presidents. If I fail to meet the demands which benefit one worthier, remember that you are in part to blame for so gracefully tendering the office, and share with me the responsibility of making this meeting a success. I shall not attempt to weave garlands of fair words, but in plain language and briefly will utilize the time allotted to me in an attempt to emphasize some matters which are engaging the attention of the medical profession as well as of the thoughtful citizens of the state and country. It is well known to all of you that in every state in the Union and in al-

most every county, the most thoughtful, prominent and successful medical men are banded together and are earnestly working “to extend medical knowledge and advance medical science, to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws, to promote friendly intercourse among physicians and protect them against imposition and to enlighten and direct public opinion in regard to the great problem of State Medicine, so that the profession shall become more capable and honorable within itself and more useful to the public in preventing disease, and prolonging and adding comfort to life.” The benefits accruing from this unity of purpose and harmony of action are seen and felt and extend to the most remote and obscure sections in all parts of the United States. Nor is it a matter of surprise that this sudden appearance of such a mighty power, so long dormant and inert by reason of lack of organization, should strike terror to the breasts of those whose greed has been fed by ignorance and who have so long flourished concealed under the dark mantle of falsehood. Not that we should encounter the bitter opposition of the Proprietary Association of America, a combination made up of the owners of patent and proprietary secret nostrums, representing untold millions and contributing forty millions annually to the press of the country. It is also to be expected that those who have amassed enormous fortunes by fraudulent advertising and unscrupulous methods should be past-masters in the art of deception; and that the vocabulary of vituperative language, the recourse of the cheap politician, should be exhausted in furnishing approbrious terms to hurl at those who dare join hands to prevent the sale of ruinous and deadly drugs under false and misleading titles. That vile insinuations should be made against those most prominent in the



cause and that such terms as "cant," "Hypocrisy," "Ring," "Game," "Conspiracy," "Medical Trust," etc., should be used with the intent to stigmatise those who write or speak for the medical profession and that of the American Medical Association they should say "It scruples at nothing provided their own selfish interests can be furthered," was but to be anticipated. None but the most romantic visionary ever imagined that those to whom altruism is a myth and disease but the means of preying on the afflicted, would permit the mask to be removed and "the hope of their gain" to be destroyed without the most obstinate fight that shrewd advertisers and manipulators, unlimited wealth and corrupt politicians can maintain. Those who read the medical journals do not have to be informed of the "slaughter of the innocent," constantly being reported as the result of this nefarious business, and within the sound of my voice, there are not a few who have been called to minister to cases of poison from some secret nostrum where the specific nature of the poison or poisons being unknown, it was impossible intelligently to apply antidotes, not to mention the many cases of choral, morphine and other drug habits resulting from nostrums. There is a hardly a man in the house that has not seen the innocent babe pale, puny and weak, the result of some lauded mixture, or soothed to the border land, if not into eternity, by its own mother's trusting the diabolically false label "it contains no poison."

Gentlemen, we would be less than men did we not use every effort to secure such legislation as will at least require that all secret preparations sold shall publish along with each bottle or package the kind and amount of each poison contained, not excepting those that profess to be exploited "only to physicians." Without making any invidious comparisons, I will leave the "Great American fraud"

and briefly allude to the recent attitude of the life insurance companies toward the medical profession. Most of the counties in our state and the House of Delegates of this Association are to be congratulated on the stand they have taken in regard to the proposed reduction in the paltry amount allowed by most of these companies for the important and responsible functions of the medical examiner. These gigantic symbols of trust, arbitrary and absolute dictators of rates, etc., are among the first, when an attempt is made to resist an unjust thrust at the guardians of the threshold and protectors of insurance interest, to stand aghast and deplore this evidence of the existence of a Medical Trust. Asseverating that "it is in its essence the attitude of the Trade Union," etc., and "It is un-American and unreasonable."

I cannot do better than quote the striking comments of the Medical Times on the subject: "Underpaid in the most extravagant company and unappreciated, the medical examiners and directors have performed their work thoroughly, conscientiously and beyond criticism. Yet putting a listening ear to the trembling air, we hear no chorus of praise to the faithful physicians in their positions of trust. The only words that come along the line are commands from the companies' officers to cut down the medical expenses, already down to the bone."

It would be interesting for the Legislative Committee to call the medical directors of the companies and ascertain their pay. It would be found so meager that even in companies with one-hundred-thousand-dollar salaries it would be laughable were it not pitiful. These medical directors control the lifeblood of the company. Their work is the heart, body and soul of the company's existence and yet these men, intelligent, skilled and honest, are frequently forced to take prac-

tice to keep up their homes in proportion to the dignity of their positions.

When it comes to the examiner the companies scarcely consider him at all. Even the select few who devote their entire time to examining find it hard pickings. For example, a principal examiner of a principal company in a metropolitan city stated recently: "I sat in a man's office for an hour, waiting to examine him for a ten thousand dollar policy. He looked healthy and would have passed the inspection of the company as to business and social standing. But I found a systolic murmur in his heart. I saved my company ten thousand dollars, for which I get the munificent pay of *two* dollars; and this company is being criticised for the extravagance of its management. Surely, it is not in the medical department.

Some day, on that brighter shore, we suppose the doctor will come to his reward, but here we see but little of it. The physician is expected to be honest, efficient and omniscient and live on the clear pure air of his surroundings.

There is another matter which urgently demands the attention of your body, and it is most opportune that it is to be our privilege this evening to hear one of our most distinguished teachers on "The Drugs that Enslave." I get it from reliable authority that the use of narcotics and especially cocaine is enormously on the increase in our State, more particularly in the negro districts.

Some States have acted on the matter, and of Illinois Dr. Boardman, a druggist and member of the State Board of Pharmacy, said some time ago: "in the cocaine crusade, I am proud of my State. On the one side the avalanche of decent pharmacists who want the curse stamped out and who support the Board loyally and enthusiastically in every step taken in that direction; on the other side are a few paltry, greedy criminals who have no

sense of honor, decency or civic pride, who would as soon sell a member of their own family into slavery as to lose a nickel."

In our statute on the practice of medicine the definition of the Practice of Medicine is not explicit enough, nor does it allow enough latitude.

I would respectfully commend to our Legislative Committee a bill on the subject recently passed by the Mo. Legislature and reported in the Journal of the American Medical Association for Nov-1905, or the definition of Judge Greene:

"The case before him was one that absolutely demanded such a definition for its decision. Judge Greene defined the practice of medicine as 'the exercise or performance of any act by or through the use of any thing or matter or by things done, given or applied, whether with or without the use of drugs or medicine and whether with or without fee thereof by a person holding himself or herself out as able to cure disease, with a view to relieve, heal or cure, and having for its object the prevention, healing, remedying, cure or alleviation of disease.' "

Still another matter of importance to the profession as well as to the people and which should not longer be ignored, is that our statutes contain no provision for the revocation of license, not even where criminal conduct has been proven.

Admitting that the cancelling of a license is a serious matter, yet, the offending clergymen are silenced, the political official may be impeached, and the lawyer guilty of unprofessional conduct can be dis-barred. Then, why in the name of justice, should the medical profession where the community must trust so much to the physician, and the profession so depends on the honor of its personnel, be the exception?

As a member of the Examining Board, I feel a delicacy in mentioning the amendment to our Constitution relative to the



Board, but my term of office having expired and as a member of the House of Delegates, and I am, therefore, ineligible to election, I cannot refrain from reiterating the words of caution that come from the pen of my distinguished predecessor and which recently appeared in our excellent Journal. "We see no objection to electing medical examiners every two years, but to limit them to a single term of office would in our opinion be a great error. Upon these men devolve the important duties of protecting the profession and of safe-guarding the public from incompetent practitioners and such high office should not be given *merely for the honor that attaches to it*. Ability alone should determine the selection. An examiner should possess a nicely balanced judgment, a fine sense of discrimination and a fair mind as well as ability to frame questions clearly and tersely. These qualities grow with experience, the competent examiner becomes more and more competent as the years pass. The proposed resolution would lop off the branches just as the buds begin to open."

In conclusion, gentlemen, we have seen and we shall see many of our efforts at securing legislation failures, for we have much to contend with. Ignorance of the real conditions is one of the greatest obstacles and it is to be regretted that there is a growing tendency in our state to put a premium on dishonesty. He who swears falsely pays lower taxes and regards the honest man as a species of innocent imbecile, and he who secures office by bribery may be expected to turn an open hand to receive the delicately tendered token of appreciation for services, whether it be by whiskey trust or the no less crafty and powerful nostrum association. Take in combination with the above conditions a more or less suborned press including some medical journals and we see what formidable opposition we must meet. On the other hand we are no longer the

straggling bands of a great army dissipating energy by internal friction and forming an easy mark for any organized opposition. It is no excess of zeal to say that if necessity demands it, when exercised in the cause of humanity, we are capable of manifesting enormous political power, with approximately fifty thousand of the most influential physicians in the land; embracing two thousand, four hundred, of the two thousand, eight hundred and thirty counties and extending to almost all of the more intelligent homes of those counties, the most obtuse politician can see that we are in position to demand recognition. While there is much hard, and often unpleasant work ahead of us, yet as I look before me I see men accustomed to contend against difficulties; men taught in the school of experience, having often seen the fruition of hope after long patient and painful effort; men who realize what Carlisle meant when he said, "Older than all preached Gospels was that unpreached, inarticulate, but ineradicable, forever enduring Gospel: Work and therein have well being." And men who also have "learned the luxury of doing good."

Gentlemen, I thank you.

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#### SUBSIDIARY CONTRIBUTIONS TO MEDICAL SUCCESS.

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At no recorded period of time has the medical profession occupied so lofty a place as it does to-day, and at no previous epoch have its devotees and their method been more severely criticised. At such a juncture it behooves all who are interested in the welfare of the physician to avoid any real cause for offense, and rather to consider well professional tendencies to failure, fault and sin.

Observers of medical habits have identified a strenuous willingness upon the part of medical men to accept recognition

secured through meretricious methods. Many of those, presumably sublimated by long dalliance in realms of medical empirics, have been charged with the adoption of unworthy methods in order to maintain professional vantage grounds. Once entrenched, the habit is to continue the professional plaguerist, appropriating as their own the rightful belongings of medical brethren.

There is a method of popularization which receives homage from the physician who upon elect occasions and times assumes a busy air, or hastily refers to improbable numbers of visits and limitless clientele.

Many up to date medical men indulge in reversions to aboriginal manners and methods by playing childish games, like to "hide and seek," "tag," "pull-away"—making much irrelevant outcry, awakening anthropologic echoes of "pursuit and capture." For these exhibits of primordial medical instinct no rules are supposed to be necessary. No league law, no centralized prerogatives, no umpire, no referee, and hence no possibility of appeal to any monarchical centralization of authority, in case of questionable play, evidence a self-consciousness of virtue common to perversion. This medical madness is not without method. By turning medical seriousness into a kind of "scrimmage," the attention of the masses may be attracted, and forced to give recognition to the individual player, who thus finds excuse for airing medical non-essentials which cannot be admitted to any real medical contest. The players are not prohibited from introducing any element that may prove attractive, even though picturesque and as remote from medical merit as appearance, physique, temperament, accident of birth, social position, respectability, etc., so long as these can be made contributory to place, popularity and emoluments. Individual players of the games of medicine are of gregarious habits, and "of the herd," and therefore require combination into teams, and a possible future alliance with the "Contemplated Brotherhood of Medical Conspirators." The team work is never given an airing in an open field in fair fight,

but the players are bought and sold like chattel, although fully cognizant of the fact that engagement guarantees permanent, physical, mental and moral injuries. Each signature is but an autobiography of personal failure. The Omega and paramount end of these teams or trusts is linked with its Alpha in the familiar phrase of Juvenal: "Bread and Games." To maintain these have been sold medical birth-right; and even conscience, once pre-empted as the abiding place for sacred religious belief, has been known to submit to preemptory and sudden eviction at time and place co-incident with alliances formed to gain professional exaltation, through subterfuge.

The medical office building, with its combines of specialists, presents a somewhat picturesque likeness to a church bazaar, with its confusion of tinsel, booths and things for show and for sale.

The enterprising head of one booth interprets it as his duty to introduce you to the head of another booth, and thus the business is kept moving. The hospital buildings, with their foundations securely placed in earthly charity, and their lofty superstructure of human service, reaching upward into the face of Heaven, are razed to the level of earthly selfishness, by hospital combines and trusts, of acknowledged potencies, for professional usurpation and exclusiveness. Their real objects too often profaned, these hospitals may be likened unto vast commission houses, with their corps of agents, promoters and attaches, rewarded by dividends and commissions, payable in the coin of the realm. Together, these office building trusts, and these hospital trusts, convert the centres of medical traffic into a veritable Avenue of Liberty, with dealers, general and special, wholesale, retail and commission, in medical and surgical commodities and luxuries, wherein the prices of prognoses and pills are subjected to the same laws of market fluctuations as pumpkins and potatoes.

Team and trade trusts abound, and are inclusive of the "mental and instrumental trust," the "spectacular specialty and spectacle trust," the "proprietary physician and medicine trust," and some more.



Of growing importance is the "trainer and trained nurse trust," and has been objectified where the nurse-elect could not or would not resist the temptation to secure an emergency call from one of her trainers, during the temporary absence of the regular attendant. It is the medical game of "two to one." A member of one of the most prominent "pillars of piety trusts" once complacently admitted that he owned his "calling and election" to the unremitting methods he adopted of paying his pew rent in advance. Trusts are here, there, everywhere, and in everything, except the trust in the trend of medical things toward the triumph of merit.

Not, alone, amid the centres, is this medical entrenchment in evidence, but upon the byways and highways, the kinships of spirits and methods announce their clamorous medical competitions, diminished only by numbers and corresponding attenuation. In all the mineralogy of medicine there seems little gold worthy alchemistic isolation, or that may *not* be discounted by vulgar success attainable through simulation.

By the rand and file, and by the old and the young, there are self-estimates proclaimed and prerogatives exercised which have nothing to do whatever with real medical or surgical evaluations. Men whose copyrights upon routine practices and prescriptions should have expired long ago, proclaim their seniority—and receive recognition—because some people prefer to take their advice as they do their medicine—"simply because they are old." The young man flaunts his higher education and present-day advantages—and sometimes boastfulness of pre-emption of medical throne and peerage through lineal medical blood. Responsive to this echo of the Hippocratic Oath, there are some reverential tremors imparted to living lips. Lineal descendants of the "father of medicine" must remember that Hippocrates was the sixtieth time grandchild of his progenitor, Esculapias, who was the son of Apollo, and, therefore, only somewhat of a God. Furthermore, it must not be forgotten that

Hippocrates was born 2,365 years before this generation. The haemoglobin is entirely too diaphanous to warrant medical practice, because of relationship with this, divinity. The blood is too far removed from its God. It would rather suggest to the weary corpuscles the need for change of itinerary. They who boast of, and they who regard, lineal blood as possessing worthiness like to merit, are encouraging subsidiary measures. Accidents of birth are not to be regarded as any part of the physician's scientific value. Neither are the elements of glibness of tongue, nor so-called tact to be thus regarded. At one time rewards of medical popularity have been given those presenting certificates of insolvency; at another time, they have been secured by letters of credit. Even shiftlessness, with its sequential impecuniosity, dare hope for reward where merit is ignored. As medicine stands to-day the principles of fraternity are nullified by numerous brotherhoods and fraternities of varying grades and character. The fraternity at the left of the procession is the medical fraternity. Especially is this made apparent in most health and life insurance fraternities. There are thousands of ways that may be adopted by those who desire to insinuate themselves into public popularity for purposes of self-aggrandizement, just as there are thousands of ways of going wrong in practice of medicine and surgery, and the wonder is that the profession is not more frequently placed in serious peril.

The most deplorable and most universal method of securing popularity is by giving cheap access to skill and experience. As the physicians' popularity increases, the larger the number of his visits and interviews. The appearance of a worthy opponent's name in the neighborhood becomes an incentive to renewed vigilance and greater exertion. Instead of thirty interviews, these are liable to an immediate increase to fifty, without augmenting the diurnal return of dollars. Men who have long been due on Easy Street, and to whom a new arrival of medical equipments should be a suggestion for their retirement, will rival

a Whitechapel Jew in "smart" business, against exceptional gifts of one without experience, in exploiting the greatness of the handicap of inexperience and self-distrust, characteristic of young medical noblemen. The profession contains some Solomons and Moseses who "spot" the earliest as well as the latest promises of success. Further shrewdness is occasionally utilized for the purpose of creating or stimulating demand for services. Accompanying these displays of business equivalents, is an affected ignorance of well-known names and superior skill of professional representatives "not of the herd."

Like to the abnormal thirst that oppresses the dropsical patient, there is a longing for increase of clientele by some who have already more work than they can perform. Medical drugery is succeeded by medical torture to those who have neither mercy upon themselves nor consideration for others. It was recently admitted by a capable physician, who had been allured by the "foolish fire" of public popularity into excessive work, that each new convert who voluntarily or by inducement, became an agent to spread his name, was one more addition to the number of those who would not permit him to steal away for rest, and who would be liable at any moment to sense some personal neglect when he should desert his place, by inventing a trivial excuse for his employment, and thenceforth become busy in attempts to establish a panic. Even his dreams of rest were abbreviated through his own successful attempts at centralization of public popularity. These men entitle the profession to the charge of disregard for the holy Sabbath. They neglect sacred duties in their mad rush for popularity, and they claim they have no time for thanksgiving. They constitute the medical ungroomed of body and the professional unregenerate in heart. "They have entered the merciless circle of greed for dollars, and in the struggle feed upon their kind." The popular cry that the medical profession is crowded emanates from these; and, if the profession be crowded, it is due to their monopolistic methods. There

is more than enough for all to do in the practice of medicine and surgery in this country, if the work were fairly distributed, and the system of awards were less like contract work, destitute of plans and specifications.

The physician who seeks, strives, and breaks down, in efforts to secure and maintain limitless medical clientele, does so for other purposes than the larger good. He may be impelled to labor because restraint would cost him or his household something. These physicians make the pace for those who are more independent. Men may thus think to find excuse, amid seeming opulence, to neglect or abuse talents, upon the principle of self-preservation, and resort to pretense and simulation. A point is reached which is somewhat removed from these necessities, at which men of genius should make their objections. To share in the general evil of our times, poverty, is the part and lot of the physician, and it always has been. It is the soul of the physician which impels him to do something, at all times, to lift or mitigate this horror from the world, even though poverty may menace his own life. The temptations of need place him in the greater dilemma of perverting his powers, or if these will not yield, they will be useless. The power of money has not hitherto weakened the majority of medical efforts, even though its possession might become corrupting. To secure for the physician more than a competence would not make him better than some of those whose history has made for medicine its name and glory. The millionaire medical man may mean well, but it cannot conscientiously be said that he has even been known to do well. The medical profession must not presume to that wealth which comes only to a very few of those who make its acquisition the entire object of their lives. Yet the endurable minimum, for the medical man, is reached where hope, honor, attention, and material things, fall short of the full standard of his conception. To prevent need, without inducing other and perhaps graver ills, or deterioration of the tissue *medico moral*, is a question demanding much thoughtful



consideration. The efficiency of any philosophy appeals hopelessly to one who recognizes his own status, and becomes consciously alive to his own cramped plane, as exhibited in medical life to-day.

In other lines, worth is rewarded by the employer. Labor receives consideration for its merit and needs, in apportioning the pay upon sliding scales upward to grades of efficiency and utility. But, medical men persist in giving services, inclusive of experience and skill, at the same market price as those lacking in these things; and, furthermore, they seek to corner the market at the lowest figures. At least fifty per cent. of the income of the profession is thus counteracted. The loss aggregates thousands of dollars to each, and multi-millions to the profession at large. The sad facts are within living memories, that in my native State of Pennsylvania, there in the wealthiest county in the world, there where the best skill of surgeons and physicians are needful to the conservation of the large interests of traffic and trade; there in that Mecca of Mammon, where we mould in glass, fashion of steel, or dig from the mines, a millionaire, whenever it seems desirable or agreeable; there have lived and died medical and surgical noblemen, who have left at their graves, debts, which they could not have personally satisfied so long as they continued to perform their parts in harmony with their full conceptions of mission and ministry to humankind, had they lived to be as old as Methuselah. Men, who, employ the best of themselves in medical practice, will not be able to give personal matters any considerable attention.

One of the most deplorable losses, because touching the vital principle of medical science, is that occasioned by perfunctory or faulty service. No work can be the best work, if it be done under pressure. Victims of the double-edged blade "overwork" are to the right of us, to the left of us, and some are of our very own. The physician, made prominent through public popularity, fallaciously regards himself successful in proportion to the excess of his work, or the receipts of his

office. The medical soul-life is departed from him to whom no intimation comes of duties half performed under stress, and whose conscience is not sometimes pursued and overtaken by regrets because of want of time to change, alter, rearrange or concentrate methods, hastily adopted to meet the ever-increasing demands upon experience and skill.

There are months, perhaps years, of inefficient effort, which the honest physician would fain cast behind him, resulting from work, which was performed under stress. There are times and occasions when physicians work too much, and the results upon their professional status is oftener in evidence than they have either the time or the inclination to consider. To maintain real place and power, the physician must show respect for periods well observed, the halts for research, and those seasons of refined thoughtful quiescence, necessary to the development of the best of self. In many cases, and at recurring intervals, it would be infinitely better for the physician, the profession, and the public, if the overworked physician would turn aside, rest his horses, and take a holiday, or cultivate some area of his knowledge that has lain fallow. If the physician's needs prevail against such incentives, the profession and the patron would be gainers, if the physician were salaried as much for refraining from work as for working.

Nevertheless, physicians are to-day striving to transcend their own possibilities, so that individual work may exemplify, not only the best of self, but the best that each and all together can do. These are the disputed cases for which this argument was inaugurated. These men are far above sham and imitation, nevertheless, within the range of average investigation, but against whom the conditions of this moment are proving unkind. It must be admitted that a mutuality between the individual and his environments are needful to human perfectionment. Certain conditions are necessary additions to inherent powers, however capable. Because he demands that the only work entitled to remuneration, either in gold or gratitude, be the best work, shall

the physician, therefore, be compelled to unduly bide a time when merits and rewards more happily meet? It seems that generous civic response should yield, with utmost celerity, that intelligent and appreciative atmosphere, in which his mission shall be best accomplished. Furthermore, a capacity for understanding upon the part of those whose interests are subserved, should be made as obligatory as personal training or fitness. There should also be included the necessary assurance—not always a worldly one—that the efforts are “worth while.” Physicians have lived and died, who have missed these phenomena of vital import, and both they and those whom they attempted to serve, were erratic in aims and effects. No Plato could have lived in the Heroic ages. Newton could not have survived the Heptarchy. Accidental successes may appear, despite all these things, with which this plea has nought to do, and doubtless there be those who are not deserving of what they get; nevertheless, there are worthy ones, for whom we are most concerned, who are not even receiving judgment. Precious knowledge, attained by self-sacrifice, through almost inaccessible channels; and lives, of noblest possibilities, have been wasted and inhumanly ignored, even while the meager services permitted have paid enormously to humankind.

The prescriptions of physicians are known to be continuing life-saving possibilities, although their authors are far removed into eternity. Despair, and even suicide, have been charged against medical monopoly attained through public popularity.

There are moral losses to the profession, by and through commercial combination, which are above all mercenary accounting, and beyond mental and material things, and these signify to the organized conspirator the price of blood and honor. Such “organization” in itself indicates disintegration of medical body and spirit. That moral sense is paralyzed which forces the high mission of the physician to parade in mimic guise, and can be satisfied with the pseudo-success such parade may bring; and

the practice of these insinuating methods entitles those who are guilty thereof to a “disesteem which it would be flattery to call disgrace.” The advantages of higher medical education, and present possibilities, are of no avail, when they are so easily counteracted by an atmosphere of subterfuge, in which it seems a “fool’s errand” to even aspire to an adjudication of work as work.

At this moment conscientious medical men, inspired with candor, personal fitness and generous respect for lofty capacities, are championing the cause of higher education. At the same moment little worthy discrimination of medical merit can be accredited to the masses who are the real beneficiaries. So long as the individual human unit regards the popularity of the physician as the *sine qua non* of professional largeness, and thinks it a sufficient excuse for evading personal investigation, or inquiring into the real merit of the work done, the temptation will remain to the physician to take advantage of the public by securing popularity; and those who can not rival successfully their professional brothers in attaining this *quasi* endorsement, will resort to pretense and simulation. Shams give death-dealing blows to true merit in the community at large. Moreover, there are subsidiary elements, which continue to enthrone a physician, long after the work emanating from him has died and been forgotten. It has been and is now, the popular fallacy, that the physician doing the *most* work is doing the *best* work. Therefore, in the vocabulary of the masses, quantity becomes the synonym for quality.

After centuries of experience, not without record, physicians know so much about the people that they are not greatly affected with wonderment, when the masses turn aside from the “divine art” to take up the worship of “false gods.” A greater surprise awaits him who appeals to the public in behalf of the physician. Either from witlessness or wantonness, the response to the plea of a physician, and those emanating from the public, come through a common channel—that of “philanthropy.” A physician



who takes up the cause of the profession before the public is too often regarded as cynical, or thought to be assuming the attitude of almoner. The philanthropic public gives less heed to the arguments offered than to their own imaginings. The physician never was a unit in the long procession of alms seekers, neither has the profession ever turned towards the public in a compromising attitude. The pages of history record far more trying times than the present, and somehow they managed to take care of themselves and their own, and, by their unselfish efforts, succeeded in placing the world under a debt of everlasting gratitude, by keeping it physically capable. It were vain for the physician to even hope to receive credit for all his good purposes; but it is just now that we must seek to stifle unworthy accusations, and earnestly endeavor to correct unfair estimates of his worth and work. If some of the intelligent public would criticise the physician less, and cease to bestow needless "pity" upon him, or could be persuaded to turn their attention to their own real business, in relation to the profession, by making proper estimates, and giving fair recognition to medical and surgical work, there would be less muddle and smaller troubles for all concerned. Candor should compel the admission that, so far as medical worthiness is adjudged by lay estimates, the verdict is against the best skill. If it ever should become necessary that the physician be elected by unanimous public vote, only the obscure or unknown would survive. There would be no one, however capable, but would receive condemnation; and no one, however remote from real merit, would fail of endorsement. It will be well for the masses to remember that the largest number of those who constitute public opinion, regarding medicine, are very easily moved, and they seem to find it congenial to their intellectual powers, to easily respond. It is not unfair to ask that there be at once a cessation of either passive or active sanction to the medical pretense, trappings, tinsel, and subsidiary elements in general, which have had, at all times, fatal capaci-

ties for living off the sufferings and misfortunes of humankind. Furthermore, demand is herewith made for "judgment," that unbiased, capable judgment by which medical awards may be disburdened of secondary considerations. If this judgment can not be secured from the public, then there must be established a higher judiciary, to pass upon medical and surgical values. Here, and now, while this appeal is being made, the public ear is likely to display a want like unto wantonness, by giving attention to some intrusive blare of trumpet, at the ingress end of which there is one who devotes time and energy to supplying wind—with an overconscious modesty—which the sub-mediocre majority regards as genuine. Good men in the profession have no desire to occasion distractions which a worthless pretender will do infinitely well. It is presupposed that the capacity for judgment is within easy reach of the mediocre public if they will only heed the warning, "Stop, look and listen." This grievance is not a personal one. It is a public wrong. The profession is liable to less injury than the masses; the indifference of the multitude, and the opposition of the ignorant, the ill-report of the vicious, together with the dissensions within and without, make demand upon more than ordinary endurance. Some time must come collapse or ardor, and the best will be forced to the wall.

Popularity of the physician neither approves nor condemns. The number of the physician's patrons and his emoluments are results, independent of merit. Some may be overpaid. It is our concern to look after the interests of those really meritorious who are underpaid—the good physician's necessities, not his luxuries. An entire separation of the needs or rewards, of painstaking and honest medical and surgical practice, must be forthwith made, from the accidents of the market for services, suggested through subterfuge, by individual medical aspirants to honor and emoluments—especially the latter. The law of supply and demand breaks down completely between patient and physician. If

the individual cannot, or will not, come up to the full appreciation of medical merit, some way should be devised whereby we may sustain those who are capable to discharge the necessary public functions of the physician.

Once a physician has proved his quality, the question of income should be irrespective of the amount of his services. Medical men, when properly sustained, will continue to work, once they have worked, especially if the incentives of further honors, and further emoluments are not withheld. No logical judiciary for surgical and medical work could proceed from public or miscellaneous endorsement. No adequate measurements could include capacity and emoluments, as estimated by a general standard, and there could be no single supremacy of judgment. Notwithstanding all these things, there are several ways by which it is possible to protect the physician from pressure of immediate necessities, and secure his life against the obligation to work perpetually.

One method, which would seem to meet the present contingency, is that of an endowment or guarantee fund. This might be from the public, or add another of the privileges to the overtaxed donor. This endowment should mean status, reputation, and opportunity. By persistent high quality, this method could win its way to authority and distinction.

For every one hundred thousand people we might subsidize one physician, if so large a proportion of worthies could be found. Give to him title or honor, and the alternatives of doing general or special medical or surgical work, at a stipulated price, or a fixed income. From these again, could be formed a committee, with honor and income proportionately exalted, to whom names proposed for endowment, might be suggested. This election should be entirely involuntary on the part of the individual. It will be admitted that this thing may be done stupidly, dishonestly, and vulgarly; and some shy ones may not approve of the rude sanity involved in the suggestion. But the total cost would be trifling compared to the ultimate salvage to hu-

man life, public comfort, and universal welfare. The public is already paying more for less return than these suggestions would secure. This method would feed the noblest and deepest medical impulses, instead of paying royalties to subterfuge, or that which is unworthy. Furthermore, it would recreate those who have labored long, and have borne the burden and heat of the day, without recognition. For all this, there would be forthcoming as a result, an elevation of the medical standard and effort. Ambitious students would show to greater advantage and all discouraging and disgraceful medical competition would cease.

Those who would presume to endow medical worth must have largeness of mind, sufficient to evade subsidiary elements and all other of questionable value. Furthermore, the reward must not be burdened with any secondary considerations. Above all, no flavor of charity should embitter it to a worthy physician; and, last, but not least, he should not be humiliated by proof of want. If solvent, the physician is yet worthy of stimulating recompense; and if, perchance, shiftless, this misfortune should entitle him to no more. If a physician does the work allotted to him, no matter what his character, he should not be separated from just reward. We must deal with work as work.

To find the original thinker and the nobleman in medicine; to define him; to discover his methods and habitats; to know his nature and life history, is the part of the committee, after once it is established. The physician-elect must not be imitative, only, but he must be initiative also. Medicine is not like sculpture or painting, where the greatest achievements are secured through the most perfect deception. The nomination and election of one, not desirous of such distinction, need occasion no feeling of disgust, unless the committee be guilty of error by suggesting the name of an individual who lacks the essential worthiness of appreciation.

It may be assumed that it is hereby proposed to make an aristocracy of medi-



cine. No possibility of such result can have any foundation. The aristocracy of medicine never has arrived, and never can exist, except that which can be demonstrated by the aristocracy of sacrifice by the body of medical monopolists of good offices, by their greed displayed in securing the privileges of doing that which belongs to another to do, and their ambitions to accumulate nothing material from the output of immeasurable life and duty, and by the common perversity of keeping business and service separate, and the lines of the "life material" and those of the "psychic animation" distinctly marked.

He whom nature purposely endows, or singles out to be useful to others, in the physical stage of human action; he who is created to mark out the height and depth of human sentience, and to deepen, by his individual possibilities, the line of demarkation environing that which is organic; to whom is given capacity to measure earthly limitations and to comprehend its possibilities, must owe all that he is or can be to these gifts. Untrue to this infinite and supreme dedication, he can be nothing to his trifling self. There is an ideal glory in medical servitude which writes "holiness" upon all things—material or psychic—that is but a reflection of the great "dedication" when clothed in human flesh; the only Son of God received His commission as Great Physician—and, with gracious features made more brilliant by a nimbus of glory flashed from the altar, close by the throne of the Almighty Father, He came down to the barren heaths of human woe to heal the sick, restore sight to the blind, and to make the lame to walk.

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#### A LETTER FROM THE PRESIDENT CONCERNING INSURANCE FEES.

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Charleston, S. C., May 16th, 1906.

To the members of the South Carolina Medical Association: Whereas there seems to be some difference of opinion as to the intent of the Resolutions adopted by the Association at its recent meeting in Columbia with regard to Life Insurance

fees, I deem it advisable to write a word or two thereon. It may not be inappropriate to quote the Resolutions as passed by the House of Delegates on April 17th, 1906:

"WHEREAS, as many of the life insurance companies have notified their medical examiners of a reduction of the examiner's fee from \$5 to \$3 and whereas we, as physicians, realizing the responsibility incident to the proper examination of the individual, believe that reduction to be unjust;

THEREFORE RESOLVED, That we, the House of Delegates on session assembled, do hereby declare such reduction to be unjust, and respectfully request that no physician legally authorized to practice medicine in South Carolina adopt such reduction of fee and further, that any physician accepting such reduction shall be guilty of breach of professional courtesy.

RESOLVED, SECOND, That it is the sense of the House of Delegates that hereafter in each examination of life insurance in which a urinalysis is required, the minimum fee shall be \$5, and that where no urinalysis is required, the minimum fee shall be \$3.

RESOLVED, THIRD, that the several County Societies forming this State Association be requested to adopt these resolutions."

In view of the above Resolutions, it seems to me that the course is perfectly clear, that no insurance examination requiring a urinary examination should be made for less than \$5, and that no insurance examination not requiring a urinary examination should be made for less than \$3, therefore even Industrial or Fraternal insurances should not be accepted for a fee less than \$3.00. This is the gist and the intent of the Resolutions as passed by the House of Delegates; and it but remains for the County Societies to pass similar Reso-

lutions, so that there can be no possible excuse for members infringing or evading the spirit and intent of the above Resolutions in any manner whatever.

It would also be a good plan for the County Societies to adopt the Resolutions as recently adopted by the Medical Society of South Carolina (the Charleston County Medical Society):

(3) "MOVED: That no member of the society be permitted to enter into an agreement with any Life Insurance Company to work for a salary of less than \$5 per examination.

(4) RESOLVED: That this Society consider as an "Old Line Policy" any policy, the face value of which is one thousand dollars or more and which is not written by what is known as a 'fraternal organization.'

(5) RESOLVED: That no member of this Society shall consult or have professional relations with Medical men non-resigns his membership for the purpose of engaging in insurance contract work, or for obtaining insurance work, given up by members of the Society, in accordance with the Resolutions passed this evening.

AMENDMENTS: 1. RESOLVED: That it is the sense of this Society that its members shall not consult or have professional relation with Medical men non-members of this Society who accept insurance examinations for a less fee than that adopted by this Society.

2. RESOLVED: That no member of this Society shall recommend any physician as examiner for life insurance who does not conform to the rules adopted by the Society pertaining to life insurance examinations.

By adopting these Resolutions it prevents a man from accepting a salary from an insurance company to do their work for less than a \$5 fee.

By adopting Resolution number 4, the definition as to what an "Old Line Policy"

is, is made clear and "fraternal organization" is likewise defined.

By adopting Resolution number 5, County Societies, disown, out-law any member who willingly resigns his membership in the society for the purpose of doing life insurance contract work for a fee below that recommended by the Society.

By adopting Amendment number 1, we have no professional relations with any medical man not a member of the Society, who accepts insurance examinations for a less fee than that adopted by the Society.

By adopting Amendment number 2, no member of our County Society will be permitted to recommend as an examiner any physician who does not conform to the rules of the Society in regard to prices for life insurance, whether in or out of the Society.

What has been written above seems to cover the ground in every respect, it leaves no loop hole, the course is clear, a man either errs or remains straight. By sending each member a copy of these Resolutions, no man can cry ignorance of the law, and hereafter if any member of the County Societies adopting these Resolutions, is found to have failed to have carried out the Resolutions not only in the spirit but to the letter, it is up to this Society to take action and that action should be drastic in the extreme, he should be expelled, out-lawed.

The attitude of the Insurance Companies is ridiculous in the extreme. Their explanation for the reduction of fee is absurd on its face. How any intelligent company can willingly wish to save \$2 on a life insurance examination is beyond the ken of intelligent physicians. No matter how conscientious an individual may be, he is bound to do better work when well paid for that work than he would do if he is poorly paid. The cry of economy on the part of the life insurance Companies is absurd to a degree, and why they



should seek to economize by taking money away from the physicians who have had nothing to do with the rascality, the voting of large incomes, the voting of large campaign fees to parties; but who have always given careful, conscientious, painstaking work for the good of the company, is more than intelligent men can comprehend, yet they seek to economize by depriving the physician of his just fee. If they wish, let them employ physicians outside of the Association, let them get cheaper work by cheaper doctors, and the mortality rate in ten years to come will make them sorry that they ever undertook to reduce the fees of the physicians who are really the back-bone of all life insurance.

I trust that this letter will reach every member of the South Carolina Medical Association, and every member of the profession of medicine in the State of South Carolina, and that those in and those out of the Association will realize the importance for once of a righteous indignation.

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## COUNTY NEWS.

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### BEAUFORT.

At a meeting held April 28th, of the physicians of Beaufort County, a County Society was organized and a charter applied for.

The following are a list of officers and members:

Dr. H. M. Stuart, President; Dr. S. B. Thompson, Vice President; Dr. M. G. Elliott, Secretary and Treasurer; Dr. C. M. Griffin, Dr. M. B. Cope, Dr. W. R. Eves and Dr. J. A. Whitman.

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### SALUDA.

The Saluda County Medical Society will hold its next meeting at Ridge Spring, S. C., June 4. The Medical Societies of Edgefield and Lexington Counties have been invited to meet with us. District Councilors Mayer and Croft are expected to be present, also some members of the profession from Columbia and Augusta. A picnic dinner will be served at the Spring by the local fraternity.

D. B. FRONTIS.

## PRIORITY OF DR. BAKER'S OPERATION FOR PUS TUBES—A REJOINDER.

Charleston, S. C., May 10, 1906.

To the Editor:

DEAR SIR—In the last issue of this Journal, Dr. I. S. Stone claims the priority of the method I lately devised for the removal of Pus Tubes. I wish to thank Dr. Stone for writing this article substantiating the original work he has done in successfully removing Pus Tubes. Also to express appreciation of the pleasant allusion he made to my paper.

Now, in regard to the method in question—I grant Dr. Stone all he claims, but I was not aware that any literature had been written describing the method I devised, or that Dr. Stone or any other surgeon had been doing this special operation.

Yours, very truly,

A. E. BAKER, M. D.,  
Surgeon to Roper Hospital.

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## RESOLUTIONS OF RESPECT.

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FRANCIS L. PARKER, M. D., L.L. D.

At a meeting of the Faculty of the Medical College, of the State of South Carolina, held on May 10, 1906, the following resolutions were adopted upon the retirement of Dr. F. L. Parker from active duty:

After forty-one years of devoted service to his Alma Mater, Dr. Francis L. Parker has laid down the burden of his work.

Elected immediately after the civil war to the position of demonstrator of anatomy, under the late Dr. Francis T. Miles, he succeeded six years later to the chair of anatomy, which he has filled with honor ever since. The many excellent preparations and dissections preserved in the anatomical room bear silent witness to the zeal and energy with which he labored. For a number of years Dr. Par-

ker was also clinical lecturer upon diseases of the eye and ear.

Upon the death of Dr. R. A. Kinloch, in 1891, Dr. Parker was called to the deanship of the faculty. His term of office has covered a most important and eventful period in the history of the College. The lengthening of the session, the extension of the curriculum from two years to three, and then to four, the growth of laboratory facilities, the establishment of the College of Pharmacy, and the admission of women to the study of medicine and of pharmacy, are the most noteworthy changes which have occurred during his incumbency, hand in hand with which has gone a marked increase in the material prosperity of the College. In his declining years he may justly contemplate

with gratification and pride the rich fruit of his life's labor. Be it, therefore,

*Resolved*, That his colleagues of the Faculty of the Medical College of the State of South Carolina record their sincere appreciation, not only of the valued services of Dr. F. L. Parker as professor and as dean, but also of the earnestness and singleness of purpose with which he labored for the upbuilding of his alma mater.

*Resolved*, That in his retirement from active work he carries with him the assurance of the affection and esteem of his co-laborers.

By the Faculty,

Attest:

J. SOMERS BUIST,

*Secretary.*





# MINUTES OF THE HOUSE OF DELEGATES

## Of the South Carolina Medical Association, Fifty-Eighth Annual Session.

The 58th Annual Session of the South Carolina Medical Association began with a meeting of the House of Delegates, in the House of Representatives, State Capitol Building, at Columbia, S. C., at 2 P. M., on Tuesday, the 17th day of April, 1906.

President Davis Furman being delayed by a late train, the House was called to order by Vice President D. S. Frontis, and adjourned to 4 P. M.

At 4 P. M. the House re-assembled, with President Furman presiding, the following officers being present:

Davis Furman, M. D., Greenville, President.

Crown Torrence, M. D., second Vice President.

D. B. Frontis, M. D., Ridge Spring, third Vice President.

T. P. Whaley, M. D., Charleston, Secretary.

C. P. Aimar, M. D., Charleston, Treasurer.

Doctors T. G. Croft and C. B. Earle, appointed by the chair to act with the Secretary as a committee on credentials, submitted the following report of Councillors and Delegates present, which was on motion adopted:

E. F. Parker, M. D., Charleston, Councillor, first District

T. G. Croft, M. D., Aiken, Councillor, second District.

O. B. Mayer, M. D., Newberry, Councillor, third District.

J. W. Jervy, M. D., Greenville, Councillor, fourth District

R. A. Bratton, M. D., York, Councillor, fifth District.

F. H. McLeod, M. D., Florence Councillor, sixth District.

Walter Cheyne, M. D., Sumter, Councillor, seventh District.

### DELEGATES.

Abbeville County, J. R. Bell, Due West; Aiken County, B. F. Wyman, Aiken, W. E. Mealing, Aiken; Charleston County, C. W. Kollock, A. J. Buist, B. W. Hunter; Cherokee County, B. L. Allen, Gaffney; Chester County, J. P. Young; Clarendon County, H. L. Wilson; Colleton County, J. T. Taylor, Adams Run; Darlington County, W. A. Carrigan, Society Hill; Dorchester County, J. B. Johnson, St. George; A. R. Johnston, Reevesville; Edgefield County, R. A. Marsh; Florence County, N. W. Hicks, Florence; Georgetown County, C. Williams Bailey; Greenville County, W. C. Black, C. B. Earle, Greenville; Hampton County, M. B. Munson, Hampton; Kershaw County, W. J. Dunn, Camden; Laurens County, W. D. Ferguson, Laurens;

Lee County, N. Y. McLeod; Lexington County, D. M. Crosson; Marlboro County, J. L. Napier, Blenheim; Newberry County, J. I. Bedenbaugh; Oconee County, D. L. Smith; Orangeburg County, A. S. Hydrick, W. L. Pou, Orangeburg; Pickens County, W. A. Tripp, Easley; Richland County, J. I. McIntosh, J. J. Watson, R. W. Gibbes; Saluda County, D. B. Froustis, Ridge Spring; Spartanburg County, J. F. Williams, Geo. R. Dean, R. G. Hamilton; Sumter County, F. M. Dwight, Sumter; Union County, J. H. Hamilton, Union; Williamsburg County, L. B. Salters; York County, M. J. Walker and J. E. Massey, Jr.

C. P. Aimar, M. D., Treasurer, submitted his annual report, as follows, which was on motion received as information and ordered spread on the minutes:

### REPORT OF TREASURER.

To the President and Members of the South Carolina Medical Association:

Gentlemen:

I have the honor to submit the following report:

Balance cash on hand April 10th, 1905.....	\$262.22
Cash collection April 10th, '05 to April 16th, '06 .....	2,623.45

Total .....	\$2,885.67
Expenditures April 10th, '05 to April 16th, '06 .....	1,831.81
Balance cash in bank.....	\$1,053.86

Included in the above, is the following cash received and expended on account of the Journal: Cash expended for printing Journal, etc., June 27th, 1905 to April 3rd., 1906..... \$1,191.07  
Cash received from Advertisements, etc. .... 487.37

Actual cost of publishing Journal, June, 1905 to April 3rd, 1906 10 months \$703.70  
Also beg leave to report the following, which is not included in the above:

### FUND FOR THE PROSECUTION OF ILLEGAL PRACTITIONERS.

Sept. 8th., '05 Cash received from Dr O. B. Mayer .....	\$179.00
Dec. 3rd. '05 and April 1st, Interest on Deposit .....	2.73
Total .....	\$181.73

Cash expended upon order of Dr. O. B. Mayer .....\$85.00  
 Exchange on check..... 25— \$85.25  
 Balance Cash in Bank.....\$6.48  
 Respectfully submitted,  
 C. P. ALMAR, M. D., Treasurer.  
 Examined with vouchers and found correct.  
 EDWARD F. PARKER.  
 For Council.

April 16th, 1906.

T. P. Whaley, M. D., Secretary, submitted the following report, which was on motion received as information:

#### REPORT OF SECRETARY.

Gentlemen of the South Carolina Medical Association:

As Secretary of your Body, the constitution requires me to make a report; and I therefore submit the following:

"I beg to say that the membership in the Association has increased to such an extent that we have upon our roll about 587 members, and in the majority of instances the county societies to which these members belong seem to be in flourishing condition. I would also say that the work of the Secretary is correspondingly increased; and that I have found it an exceedingly difficult matter to keep the affairs of the Association with the county societies in as good a condition as I would desire. Quite a number of the county Secretaries are very efficient and seem to take considerable interest in their work and readily reply to the majority of communications sent them, others seem to be Secretaries in name only, and are very delinquent in correspondence with your Secretary, and in many instances it has been impossible to gather the information that I desired from time to time.

I think that the present method of collecting the dues is faulty in several particulars. In the first place, I do not believe that the Secretary should have anything to do with collecting the funds of the Association. This duty should devolve upon the Treasurer, who is paid for that purpose. In the second place, it is not necessary for the funds of the Association to pass through so many hands. If the funds were simply remitted to the Treasurer, without having to be sent to the Secretary as our present constitution requires, it would simplify matters to a considerable degree.

I beg to state that I have found the co-operation of the Treasurer in every department of my work to be most efficient and helpful in every way. As to a new method of collecting the dues, I sincerely hope that the Treasurer will suggest one in the report which he will present to you to-day.

I beg to advise that I have purchased the whole card index system as advised by the A. M. Ass'n. for State Associations, and that a box has been sent to each chartered county society. I regret very much that the cards sent out in these boxes have not been more liberally responded to. With the exception of but two counties (Dorchester and Oconee) none of the cards have been returned to the State Secretary as intended. I would beg the members to pay more attention to this matter, as it is only by the card index system that a complete and thorough enroll-

ment of the Association can be tabulated and corrected from time to time.

I beg to report that I found it necessary to purchase a typewriter. I, therefore, purchased a No. 7 Remington typewriter, as I deemed it necessary that the Association should have its own machine.

I beg to report that I have issued charters to all county societies applying for the same and fulfilling the requirements of the constitution. Some societies have thought it only necessary to apply for a charter to receive one, and when written of the requirements of the constitution, that is, the payment of the members' dues in advance and furnishing correct list of the officers and members of society together with a copy of their constitution, have failed to pursue the matter any further.

I beg to report that I have given due notice of the various constitutional amendments that were suggested at the last meeting. I beg also to report that I have sent provisional programs to every member upon our roll.

I beg to report that I have succeeded in securing excursion rates for this meeting. I beg to state that I have secured a new minute book for the council, properly lettered. I beg to report that I have issued a final program, which you have before you to-day, to the extent of 600.

I beg to call to your attention that the terms of office, according to law, of the State Board of Health have expired some time since and it is in order for you to select a new board. I would also suggest that some resolution or By-Law be passed prohibiting members of this Association from consulting with men who, for various or divers reasons have been expelled or suspended from any County Society in this Association; or who, by reason of their bad faith, ineligibility or otherwise are not members of the County Society in which they reside, or the adjoining County Society. A resolution of this character would soon separate the goat from the sheep and would I feel assured tend to strengthen the profession of the whole State. I am also glad to report that all the Counties of the State have affiliated with four exceptions: Beaufort, Berkeley, Chesterfield and Lancaster.

In conclusion I beg to say that I have endeavored to fulfill my duties to the best of my ability in the time at my disposal, and that I am still further at the service of the Association for any duty that they may call upon me to perform; but that I ask that the onerous duty of Secretary shall fall upon the shoulders of some younger and more capable man, believing that in nine years of service I have done my full duty to the Association and to the profession of the State.

Thanking you all kindly for the many courtesies and indulgencies which have been granted me during these nine years of service, I beg that you will not consider me as candidate for further elections to this office.

Respectfully submitted,

T. P. WHALEY, M. D.

#### REPORT OF STATE BOARD OF EXAMINERS.

Dr. W. H. Lester, Secretary of the Board, stated that the printed proceedings of the Board were submitted as their annual report to the Association.

He stated further that under the authority conferred upon the Board as to reciprocation



with other State Boards, the Boards of the following States were now reciprocated with: Virginia, Texas, Maryland, New Jersey, Illinois, Maine, Michigan, Kansas, Ohio, Wyoming, Nevada, Wisconsin, Minnesota.

The following letter from the Attorney General of South Carolina was also submitted for information of the Association, giving an opinion as to the effect of the "five year practice" clause in the General Statutes:

DR. MARY R. BAKER, Ass. Sec. State Board  
Medical Examiners, Columbia, S. C.  
Columbia, S. C.

Dear Doctor:

In my reply of April 14th to your communication of Mar. 19, I said "that in the opinion of this office, the express provision of Sec. 13 being that 'Nothing contained in the Act shall in any way affect or apply to physicians and surgeons' who come under the five years exemption clause, the provisions of the Act as to the registry and the certificate mentioned in Sec. 5 have no application whatever to such physicians and surgeons, and that being in no way affected by the Act, the status of such physicians and surgeons is precisely as though the Act under consideration, had never been passed."

You now ask, April 16th: "Can physicians who have practiced five years in another State move into this state and claim exemption from examination under the five years clause, Sec. 13? Could such physicians require the Board to issue to them a license?"

In reply, I would say, that in the opinion of this office the exemptions in Sec. 13 of the Act in question (Act Feb. 27, 1904, 24 Stat. 517) to wit: "Nothing contained in this Act shall in any way affect or apply to \* \* \* physicians graduates from any reputable college, who have been practicing medicine for 5 years,"—I do not see anything in this exemption which confines it to physicians, graduates of any reputable college who have been practicing medicine for five years in *South Carolina*, to the exclusion of those who have been practicing medicine for five years outside of South Carolina. As to licenses, the provision in Sec. 5, of said Act, is as to granting temporary licenses by the President and Secretary of the Board in the interim between the meetings of the Board to practice medicine until the next regular meeting of the Board to such persons as would, under the former Sections of the Act, be eligible for examination. The provision as to licenses in Sec. 9 of the Act is as to the Board granting, under certain restrictions, the licenses issued by other State Boards having an equal standing. In my opinion the provisions of the Act as to licenses have no application whatever any more than the provisions as to registry and certificates, mentioned in Sec. 5 have to physicians who come under the five years exemption clause mentioned in Sec. 13—and the reason is the same, to wit, that nothing in the Act in any way affects or applies to these physicians. And for the same reason, in the opinion of this office, the physicians exempted under the five year clause cannot require the Board to issue to them licenses. I understand that at the last session of the General Assembly, an effort was made to remedy by new and express legislation the difficulty which you suggest, but the Legislature not having remedied the difficulty, it is not within the province of this office to

remedy the difficulty, which may have arisen from what might be regarded as a *causus omissus*.

Very respectfully,

LEROY F. YOUMANS,  
Attorney General.

The terms of the following members of the Board of Examiners were reported as expiring with this meeting: Dr. T. G. Croft, of the second District, Dr. Davis Furman, of the fourth District, Dr. J. L. Napier, of the sixth District, Dr. W. H. Lester, at Large.

Dr. Lester also reported that reciprocal relations had been established with the State Board of Georgia, but after granting license to several men passed by that Board further investigation had been made into the character of the examination required by them, and the Georgia Board was notified that it was not up to the standard required in this State. It was found that men who could not pass the Board in this State would go to Georgia and appear before that Board, where the examinations were not as thorough, and on fewer subjects. The Georgia Board have been notified that the South Carolina Board will not reciprocate with them further unless they increase their requirements.

On motion the report was received as information.

#### REPORTS OF COUNCILORS.

The reports of the Councilors were submitted and received as information, as follows.

First District Dr. E. F. Parker, Councilor.

The Counties of Beaufort, Berkeley, Charleston, Colleton, Dorchester and Hampton comprise the First District.

In Beaufort there are only eight or ten physicians, but organized a Society there with six or eight members, many of whom paid their dues. For some reason they have never applied for a charter, and I have been unable to get a reply to several letters asking for information and urging immediate action.

In Berkeley there are only four or five physicians, and these declined to organize as they lived far apart and prepared to join adjacent county Societies. Several have done this.

In Charleston we have forty-five members with only two or three outside—these have been approached without success.

We have recently held our meetings in the handsome rooms designed for the purpose, in the New Roper Hospital and are in flourishing condition.

In Colleton the Society has nine members, only two or three physicians outside. A well equipped hospital has just been opened and is conducted for the benefit of all the members who work harmoniously for the common good.

In Dorchester we have perhaps the most effective organization in the District. The Society has twenty-six members, holds regular meetings and great interest is taken in them.

In Hampton the Society has thirteen members and the Secretary informs me that the meetings are well attended.

As Councilor, I have been asked to assist Dr. Kershaw at Meggetts, in the prosecution of an illegal practitioner, who was made to conform to the law.

The Hampton County Society asked me to aid them in a similar way.

In my District the railroad connections are poor, the physicians widely scattered over a large area in small numbers, and frequent visits have been impossible, but I have endeavored by corresponding and personal interviews to stimulate and maintain an increasing interest in the organization.

SECOND DISTRICT, DR. T. G. CROFT, COUNCILOR.

Columbia, S. C., April 17, 1906.

The Second Council District embraces Aiken, Barnwell, Bamberg, Lexington and Orangeburg. All of the Counties have been organized, and have good active Societies.

The Aiken County Medical Society have twenty-five or thirty members, meets monthly, and has generally twelve to fifteen members in attendance, with Dr. W. B. D. Wright as President, and Dr. B. F. Wyman as Secretary and Treasurer.

The Lexington County Medical Association has about sixteen members, meets every three months, and has Dr. J. L. Shuler as President and Dr. J. J. Wingard as Secretary.

The Orangeburg County Medical Society has twenty-one members, meets monthly, and has Dr. W. L. Pue as President, and Dr. Sam C. Shecut as Secretary and Treasurer.

Bamberg County Medical Society has a good membership, and is doing well. I have no record of their officers or members.

Barnwell County, the smallest of all the Societies, and not as active as the others, but in time will do good work.

The report from the second District is good, and should be very encouraging.

Respectfully,

T. G. CROFT, M. D.

Councilor.

THIRD DISTRICT, DR. O. B. MAYER, COUNCILOR.

In the third Council District every county has a good Medical Society. Each one of which I have visited during the past year I have been very much gratified with the great medical progress that was being made, as well as the increase of good feeling among the profession. I am satisfied the new movement has done much good in the third district.

O. B. MAYER.

FOURTH DISTRICT, DR. J. W. JERVEY, COUNCILOR.

Gentlemen of the House of Delegates:

As Councilor of the Fourth District of the S. C. Medical Association I beg to present the following report of affairs in my district for the past year:

I have visited, unofficially, every county in my district except Union, during the past year, and have had mutually interesting and profitable conversation and written communication with many individual members in every county in the district. Some of these counties I have visited several times. In all, except Anderson, the county societies are in flourishing condition, gradually increasing their membership, and comprising at this time probably three-fourths of all the reputable practitioners in the district. In Anderson County, however, interest seems to lag. The situation there is somewhat unusual. Temporary

enthusiasm can be aroused, but it soon dwindles away, and meetings cease to be held. This apathy toward sustained active organization has always existed, and just now, I confess, I am at a loss as to how or when to proceed to awake again a waxing interest in matters of medical organization.

In regard to the suppression of illegal practice and practitioners, we have made a good start and can say that we have accomplished something.

In the summer of 1905 I was informed by members of the Pickens County Medical Society that one Dr. G. B. Justice, claiming to be a graduate of Jefferson Medical College and claiming to hold a South Carolina State Board certificate, was in reality an impostor, holding neither diploma nor certificate. Investigation showed that he had been dropped for deficiency in studies after one year at Jefferson and that his alleged State license was a temporary license granted on Justice's misrepresentations of facts. With the assistance of our distinguished president, Dr. Davis Furman, the temporary license was quickly canceled, and Justice became a fugitive from justice. He left for parts unknown. It developed afterwards that he had been run out of a North Carolina community in the same way, previous to his South Carolina brazenry.

In and around Greenville, for a year or two past there has practiced one Dr. C. P. Price. He declined to qualify before the State Board of Examiners, and was alleged to be incompetent. Under authority of the Executive Council we employed an attorney, Mr. O. K. Mauldin, who did valuable service in prosecuting this offender. Price was convicted of illegal practice at the January, 1906, term of court, but jumped his bond and left the State. He has never returned, and probably will not. This case exerted a most wholesome influence and example upon other unqualified practitioners in Greenville County. We are reliably informed that one Dr. J. K. Huff, who, for several years practiced in this county in openly iterated and reiterated defiance of our medical laws, decided that the climate hereabout was getting too warm and more or less unsuited to his particular style of practice. He has departed, we are told, to some unknown bourne. "Dr."—so-called—Weinrach, a blatantly advertising "eyesight specialist" withdrew from this field of labor, with the earnestly avowed intention of studying reputable medicine and becoming duly qualified. A happy consummation. One herb-doctor, Sawtelle, whose specialty was a kidney panacea, and who was doubtless doing incalculable harm in his nefarious practice, also realized that the time had come for disappearing. So he quit. It is my pleasure and privilege to state that in this campaign our president, Dr. Furman, through his interest and energetic assistance was largely instrumental in bringing about these desirable results. Mr. Mauldin, our attorney, was enthusiastically with us, and expressed his earnest desire to support the profession in this laudable crusade. He deserves our thanks.

In addition to these, there are two or three really good men practicing in Greenville, and adjoining Counties, who, for one reason and another, have failed to qualify in proper manner. These men have come personally to me, as Councilor, or to Dr. Furman, as president, of the State Association, and given us satisfactory assurances that they would take immediate



steps to qualify at the earliest moment. Upon these representations we felt justified in extending consideration by not interfering with them at this time, thus to give them opportunity to redeem themselves.

All of these cases illustrate very strikingly the benefits to accrue from thorough organization. Organization means protection, and in our profession, at least, protection certainly has free-trade beaten to a stand-still. We, who have qualified and paid expensive duties in time, study, and money, cannot, in justice to ourselves or to our communities, permit cheap, unqualified, and untaxed shoddy goods to be offered in competition at cheap rates for the victimizing of the indiscriminating public. The intelligent public looks to us for protection in these matters, and we are shortcoming in one of our highest duties if we fail to provide it.

I have made efforts to get from each County Society in my district a list of unqualified practitioners. So far I have only succeeded in getting such lists from two counties, Pickens and Oconee.

There is no doubt that self-styled "Doctors," who call themselves "eyesight specialists" and "doctors of refraction and optics," are doing a great amount of harm in many sections of the State. They should certainly be suppressed. No man should be allowed to call himself "Doctor" who is not duly and properly entitled to that distinction. It cost you and me years of study, and many good hard dollars to earn that title, and we should guard it jealously and with unceasing vigilance. It is my understanding that our president will present an amended medical bill for your consideration, which will touch upon the proper and improper use of the title, and also give a modern definition of the practice of medicine, which will cover this ground satisfactorily.

And last, but we think not least, I have to report that on February 5th, 1906, in Greenville, under the auspices of the Greenville County Medical Society, we organized "The Fourth District Medical Association," comprised of the membership of all the county societies in our district. There were sixty members present, every county being represented, and the occasion was a very enjoyable one.

We shall meet once each year in one of the counties of the District, the next meeting to be in Spartanburg, in January, 1907.

Respectfully submitted,

J. W. JERVEY, M. D.

Councilor fourth Dist., S. C. Med. Assn.

April 17th, 1906.

FIFTH DISTRICT, DR. R. A. BRATTON, COUNCILOR.

Lancaster not yet organized, Kershaw in flourishing condition. Has the credit of introducing insurance fee.

Fairfield organized but not active.

Cherokee organized.

York organized and doing good work, in harmony.

Chester organized and active, adopted local fee bill, have club rooms and library—in fact through the efforts of Dr. W. B. Cox, their efficient Secretary and Treasurer, is the Banner County Society of my District.

SIXTH DISTRICT, DR. F. H. MC LEOD, COUNCILOR.

In the sixth Councilor District there is a County Society in every County, except Chesterfield. In this County, I have not been able to effect an organization. There is a District Society, which is doing good work. This Society will hold its next meeting in Marion, in July.

No suit against unlicensed men has been brought, as in every instance the offenders have either discontinued practice, obtained a temporary license or have left the State. Two cases in which suit was to have begun, left the State. Others are being looked after.

Everything in this District points to progress, and the profession seem enthusiastic over prospects as they now appear.

F. H. McLEOD,  
Councilor.

Florence, S. C., April 16, 1906.

SEVENTH DISTRICT, DR. WALTER CHEYNE, COUNCILOR.

To the S. C. Medical Association:  
Gentlemen:

I beg to report that all Counties in the Seventh District have affiliated, a new Association having been formed in Williamsburg. My attention during the year has been given to the weaker counties, with good results.

Lee County has shown the greatest progress among the Counties of the District. It has a live Association which has done much towards bringing the members of the profession together.

In all County meetings I have endeavored to emphasize the importance of the social feature as a means of bringing the members together. I think it has worked well where tried, and believe it is a valuable aid to thorough organization.

As to illegal practitioners, there was a negro practicing illegally in the town of Sumter. I had the attention of the local authorities directed to the case, and he was arrested and fined.

There is a live organization now in each County in the District, and the prospects for the future are exceedingly bright.

Respectfully submitted,

WALTER CHEYNE, M. D.  
Councilor 7th District.

COMMITTEE ON SEAL.

The report of the Committee appointed at the Greenville Meeting to select an appropriate seal for the Association was submitted by Dr. Whaley, and adopted, as follows:

Charleston, S. C., April 14th, 1906.

The President and Members of the House of Delegates, South Carolina Medical Association.

Gentlemen—The committee appointed last year to have a seal made for the South Carolina Medical Association beg to report that they have carried out your instructions. On the face of the seal is represented a mountain rising above a sea, and around the former is coiled a serpent, the emblem of Esculapius, holding a lighted torch in his mouth. The seal thus symbolizes the medical profession enlightening all sections of the State. Around the margin are inscribed the words graven over the three gateways erected by Dr. Caius at the college which he founded and which bears his name at Cambridge.

We trust that our action will meet with your approval.

Respectfully,  
ROBT. WILSON, JR.,  
T. P. WHALEY, M. D.

#### FEE FOR INSURANCE EXAMINATIONS.

The Secretary read communications from various County Societies on the subject of proposed reduction of fees by Life Insurance Companies for examining physicians. The following counties were reported as having expressed themselves as opposed to a reduction in the fee from old line Insurance Companies: Hampton, Marlboro, Lee, Colleton, Charleston, Florence, Aiken, Lexington, Darlington, Union, Oconee, York, Clarendon, Laurens, Spartanburg, Abbeville, Dorchester.

Dr. Tripp moved that the House endorse the action of the County Societies. Dr. Hicks offered a substitute resolution on the same lines. Dr. C. B. Earle opposed any action by the Association, and particularly any discrimination in fees as between "old line" and "assessment" companies.

A general discussion developed varying views as to what form a resolution, if adopted, should take, and on motion of Dr. McIntosh the whole matter was referred to a committee, appointed by the chair, as follows: Dr. McIntosh, Dr. Tripp, Dr. Hicks, Dr. Williams, Dr. Croft, Dr. Dwight, Dr. Munson.

An invitation was extended to the House of Delegates, by Dr. McIntosh on behalf of the local committee of arrangements to attend a smoker in the Speakers Room after adjournment of the evening session.

On motion the house took a recess until 9 p. m.

#### NIGHT SESSION.

The House was called to order at 9 p. m., President Furman in the chair.

#### REPORT OF COMMITTEE ON INSURANCE EXAMINATION FEES.

Dr. McIntosh, for the committee appointed to draft a suitable resolution on the subject of proposed reduction of examination fees by "old line" life insurance companies, submitted the following resolution, with recommendation that the same be adopted by the Association:

WHEREAS many of the Life Insurance Companies have notified their medical examiners of a reduction of the examiner's fee from \$5.00 to \$3.00, and

WHEREAS, We, as physicians, realizing the responsibility incident to proper examination of the individual, believe such reduction to be unjust;

THEREFORE BE IT,

RESOLVED, That we, the House of Delegates in session assembled, do hereby declare such reduction to be unjust, and respectfully request that no physician legally authorized to practice medicine in South Carolina, accept such reduction of fee. And further that any physician accepting

such reduction shall be guilty of a breach of professional courtesy.

RESOLVED, Second, That it is the sense of the House of Delegates that hereafter in each examination for life insurance in which analysis is required, the minimum fee shall be five dollars, and that when no analysis is required, the minimum fee shall be \$3.00.

RESOLVED, Third, That the several Component Societies forming this State Association, be requested to adopt these resolutions.

RESOLVED Fourth, That copies of these resolutions be mailed to the Secretary of each Component Society, and also to the Home offices of all insurance companies doing business in South Carolina. And that the same be published in the daily papers and in the Journal of the South Carolina Medical Association and of the American Association.

J. H. MCINTOSH,  
J. W. HICKS,  
J. F. WILLIAMS,  
W. A. TRIPP,  
T. G. CROFT,  
F. M. DWIGHT,  
W. B. MONSON.

Dr. B. W. Hunter moved the adoption of the committee's report.

Dr. C. B. Earle moved to amend by requiring fee of \$5.00 in all cases, regardless of requirements as to analysis. Amendment tabled.

Dr. Geo. R. Dean expressed the opinion that the resolution should not apply to companies newly organized under the laws of this State.

The motion to adopt the report of the committee was then put and carried without opposition.

#### CHAIRMEN OF STATE BOARD OF HEALTH AND STATE MEDICAL EXAMINERS MADE EX-OFFICIO MEMBERS OF THE HOUSE OF DELEGATES.

Amendment proposed by Dr. A. B. Knowlton at the Greenville session, was called up for consideration and adopted as follows:

"The Chairman of the State Board of Health and the Chairman of the State Board of Medical Examiners shall be *ex officio* members of the House of Delegates.

#### ELIGIBILITY OF MEMBERS OF STATE BOARD OF EXAMINERS LIMITED TO TWO TERMS OF TWO YEARS EACH.

Amendment proposed by Dr. J. W. Jervy at the Greenville session was called up for consideration. The amendment as noticed was that membership should be limited to one two-year term, on the Board of Medical Examiners.

Dr. Jervy: There was some misunderstanding in the wording of the amendment. The term of service was not intended to be limited to two years, and there was no specific period mentioned in the amendment as suggested by me at the last meeting, but simply that an amendment would be offered looking to the limitation of the term of service on the Board. I offer as an amendment to the By-Laws the following:

"Chapter IV. (4), Sec. 11. It shall nominate members for the State Board of Medical examiners, in accordance with the law in force



in the State of South Carolina; provided, that no member of the said Board shall be eligible for re-nomination after having served three consecutive terms, of two years each."

In offering this amendment I want it to be clearly understood that I have not the slightest desire to cast any reflection whatever upon any of the distinguished physicians who are members of our present Board of State Examiners. No man holds them in higher regard, professionally and personally, than myself, and I am thoroughly appreciative of the great and good work they are doing in lifting the standard of the profession. I do think, and upon consultation with many of the members of this Association, I find that they think, that in having members of this State Board practically specializing on one branch of medicine or surgery conducting examinations year after year on one particular branch the tendency would naturally be to drift gradually into a narrower and narrower form of examination and there is much danger of too narrow and special an examination being put up on the various branches which the State Board has now apportioned among themselves. I do not for an instant wish to suggest that any member of the present Board has reached that stage of narrowness nor do I believe our present Board would, but believe that those who follow our present Board may at any time fall into such a dangerous pitfall. My other reason is that there are many members of this Association desirous of holding positions of trust and honor in the Association. Their ambitions lie, in a good many instances, to the State Board of Medical Examiners, and I think it but democratic that the members of this Association should have an opportunity to exercise their powers.

Dr. Watson moved that proposed amendment be tabled. Lost.

#### HOUSE OF DELEGATES.

The House of Delegates met in the Hall of the Y. M. C. A. Building pursuant to adjournment, at 3 o'clock p. m., on Wednesday, April 18th, President Furman presiding.

#### REPORT OF STATE BOARD OF HEALTH.

Dr. T. Grange Simons, Chairman of the State Board of Health, presented the report of that body, which was on motion received as information.

On motion of Dr. Kollock the sum of \$200.00 was appropriated subject to the call of the Chairman of the Council for use in the prosecution of illegal practitioners.

No further business appearing, the House adjourned to meet at 12 o'clock noon on Thursday, April 19th.

#### HOUSE OF DELEGATES. TUESDAY'S SESSION.

The House of Delegates met, pursuant to adjournment, in the Y. M. C. A. Hall, at 12 o'clock noon, Thursday, April 19th, President Furman presiding, and Dr. C. P. Aimar acting as Secretary.

On motion of Dr. McIntosh, the regular order of business was deferred, in order to hear the report of the Council.

#### REPORT OF THE COUNCIL.

Dr. O. B. Mayer, Chairman of the Council, presented the following report:

The Council begs to report that owing to the resignation of Dr. Wilson they have elected Dr. J. W. Jervey of Greenville as Editor of the Journal. Dr. Jervey was requested to suggest someone agreeable to him to serve as Associate Editor, and the Chairman of the Council was authorized to appoint an Associate Editor on the recommendation of Dr. Jervey. The Council also appointed the Secretary of the Association as an Associate Editor.

They beg to report, that the terms of office of Councilors T. G. Croft and F. H. McLeod have expired. Also to call your attention to the fact that the terms of office of the State Board of Health have terminated some time since.

On motion of Dr. Parker, the following resolution was unanimously carried:

"That the Council express to Dr. Robert Wilson their high appreciation of the ability with which he has managed the Journal of the Association and to Drs. Whaley and Aimar for their efficient services as Associate Editors."

Dr. Jervey has tendered his resignation as Councilor to the Council and the same was accepted.

Dr. O. B. Mayer was elected Chairman of the Council for the ensuing year and R. A. Bratton, clerk.

It was moved and carried that 2,000 copies of the Constitution and By-Laws and Amendments be printed fresh every year and distributed with the programs.

He also reported, as a recommendation from the Council that the fiscal year of the Association be fixed, with the calendar year, from January 1st to December 31st, in order to fix the amounts due from County Societies to the State Association by the list of members on their roll as of January 1st, and to give the Treasurer from that time until the Annual Meeting to make collection and get his books in shape.

On motion, the report and recommendations therein, were adopted as a whole.

#### ELECTION OF OFFICERS.

The election of officers for the ensuing year was entered upon and resulted as follows:

President, T. P. Whaley, M. D., of Charleston; 1st Vice President, W. P. Timmerman, M. D., of Edgefield; 2nd Vice President, Henry Horlbeck, M. D., of Columbia; 3d Vice President, M. G. Salley, M. D., of Orangeburg; Secretary, Walter Cheyne, M. D., of Sumter; Treasurer, C. P. Aimar, M. D. of Charleston.

#### COUNCILORS.

2nd District, Dr. T. G. Croft, of Aiken, re-elected; 4th District, Dr. Hugh Black, of Spartanburg, vice Dr. J. W. Jervey, resigned; 5th District Dr. W. B. Cox of Chester, vice Dr. R. A. Bratton, resigned; 6th District, Dr. F. H. McLeod, of Florence, re-elected; 7th District, Dr. J. H. McIntosh, of Columbia, vice Dr. Walter Cheyne, elected Secretary.

(Councilors of other Districts hold over.)

## STATE BOARD OF MEDICAL EXAMINERS.

2nd. District, Dr. Harry H. Wyman, of Aiken, to succeed Dr. T. G. Croft. term expired; 4th District, Dr. W. L. Mauldin, of Greenville, to succeed Dr. Davis Furman, term expired; 6th District, Dr. J. L. Napier, of Blenheim, re-elected; At-Large, Dr. W. H. Lester, of Columbia, re-elected.

## EXECUTIVE COMMITTEE STATE BOARD OF HEALTH.

The House not being in possession of information as to what members of the Board had completed the term of service for which they were elected, the matter of electing the members of this Board was on motion deferred until the next annual session, the Board to remain as now constituted until further action of the House of Delegates.

## DELEGATE TO AMERICAN ASSOCIATION.

Dr. J. H. Hamilton, of Union, was elected a delegate to represent the State Association at the annual meeting of the American Medical Association.

## DELEGATE TO NORTH CAROLINA ASSOCIATION.

Dr. W. C. Black, of Greenville, was elected a delegate to the annual meeting of the North Carolina State Association.

## "HOME FOR INEBRIATES."

Dr. A. S. Hydrick offered the following resolution, which was unanimously adopted:

"WHEREAS, It is the consensus of medical opinion that drunkenness is the result of diseased states, and not of vicious habits.

Be it Resolved: 1. That it is the sense of the South Carolina Medical Association that the State of South Carolina should found and maintain a "Home for Inebriates," where the victims of dipsomania and of the drug habit could, under suitable regulations, be admitted for care and treatment.

2. That the Secretary of this Association furnish a copy of this resolution to the Secretary of

each County Medical Society, with instructions to bring the same to the attention of their respective Societies."

## MEDICINE EXHIBITS.

Dr. T. G. Simons moved that at all future sessions of the Association the exhibits of medicines and appliances be not allowed in close proximity to the hall where the meeting is held. Adopted.

## RESOLUTION OF THANKS.

Dr. N. W. Hicks moves that the thanks of the Association be extended to the Columbia Medical Association, the merchants and citizens of Columbia, for courtesies shown and entertainment provided for the members at this session. Adopted by a rising vote.

## DR. BARRINGER, HONORARY MEMBER.

On motion of Dr. O. B. Mayer, Dr. Paul B. Barringer, of the University of Virginia, was unanimously elected to honorary membership in this Association.

## NEXT ANNUAL SESSION.

Invitations were received from Bennettsville and Florence as the place of meeting in 1907. Bennettsville was selected as the place of meeting, and the 3d Wednesday in April fixed as the time for the Annual session of 1907.

## ANNUAL DUES.

Dr. Mayer, on behalf of Council, gave notice of amendment, to be acted on at the next meeting, providing for the payment of dues direct to the Treasurer instead of to the Secretary of the Association, and that amount due be fixed by list of officers and members to be sent in with remittance thirty days before the annual meeting.

The Secretary was instructed to notify the the Secretary of each County Society of the proposed change.

No further business appearing, the meeting adjourned.

## NOTES AND REVIEWS.

## PRACTICE OF MEDICINE AND CLINICAL MEDICINE.

JOHN L. DAWSON, M. D.

## DEFINITION OF THE EXTENT OF DISEASE IN LUNGS, ACCORDING TO TURBAN.

We read so often of the classification of tubercular lesions of the lung according to Turban that we think it of interest to append the "Turban classification":

I. = Slight lesion extending at most to the volume of one lobe or two half lobes.

II. = Slight lesion extending further than I, but at most to the volume of two lobes; or severe

lesion extending at most to the volume of one lobe.

III. = All lesions which in extent of the parts affected exceed II.

By "slight lesion" we understand disseminated centres of disease which manifest themselves physically by slight dullness, by harsh, feeble or broncho vesicular breathing, and by rales.

By "severe lesion" we mean cases of consolidation and excavation such as betray themselves by marked dullness, by tympanitic sounds, by very feeble broncho-vesicular, bronchial or amphoric breathing, by rales of various kinds.

Purely pleuritic dullness unless marked, is to be left out of account; if it is serious the pleurisy must be mentioned specially under the head of "tuberculous complications." The volume of a single lobe is always regarded as equivalent to the volume of two half lobes.



## PROPHYLAXIS OF LOBAR PNEUMONIA.

Anders claims that thorough and prompt sterilization of pneumonic sputum and of the secretions from the upper respiratory tract, and then their prompt destruction by burning, is a matter of first necessity. Disinfection of the bed linen and body linen the mattress and the room occupied by the pneumonia patient is also a primary requisite. These matters do not receive the rigid care and attention which they richly merit by the average general practitioner. The public measures of greatest value are summarized as follows: The issuance of drastic edicts against spitting on the sidewalks; the work of street cleaning and street sprinkling should be looked after by bureaus or boards of public health, to whom should be given full executive authority; there should be greater diffusion of popular information concerning efficient ventilation of our office buildings, theaters, courts of justice, manufacturing establishments, churches, public schools and passenger and street railway cars, and also regarding details connected with the subject of the prevention of lobar pneumonia, stating simple, plain facts about the way in which the disease is spreading.—J. M. Anders, *American Medicine*, Philadelphia, March 31.

## ATTITUDE IN ANGINA PECTORIS.

Minervini gives illustrations of the attitude assumed by a person during an attack of angina pectoris. He also describes nine cases, all showing the constancy of this attitude sign as he calls it. The individual straightens up and bends his head over backward the arms hang down or one may be placed over the heart region. If standing he leans over back against a wall if possible; if seated he leans his head over the back of the chair; if in bed the attempt to assume this attitude is plainly apparent, and he also twists his body over to the right. The aim seems to be to get away from the heart. In asthma and similar conditions, on the other hand, the patient leans forward, seeking air, rushing to a door or window if possible.—L. Minervini, *Riforma Medica*, Naples.

## PREVENTION AND TREATMENT OF PNEUMONIA.

Robinson claims that with the appearance of the first symptoms of pneumonia beechwood creosote should be vaporized more or less continuously in the patient's room. At frequent intervals the inhalations are stopped and the windows opened wide. Draughts must not be tolerated, although perfect ventilation is insisted on. Robinson regards creosote as the most useful single agent in the treatment of pneumonia, as a preventive and curative, if given properly and if continued for a sufficient length of time.—B. Robinson, *Medical Record*, N. Y., April 7.

## CIRRHOSES OF THE PANCREAS IN DIABETES.

Herxheimer's communication fills 113 pages and is accompanied by several colored plates. He has had opportunity to examine the pancreas in thirty-six cases of diabetes, and his conclusions are rather against the "islands of Langerhans

theory." He is inclined to accept changes in the parenchyma of the pancreas as the cause of diabetes. Recent research by Karakascheff and Reitmann has converted them also to this opinion. In five cases described in detail the alterations in the parenchyma of the pancreas were very pronounced. They were accompanied also by the efforts at regeneration characteristic of cirrhosis of the pancreas. This indicates that not only anatomically, but also physiologically, the essential injury inducing the diabetes must be sought in the parenchyma rather than elsewhere in the pancreas.—G. Herxheimer, *Virchows Archiv*, Berlin.

## COMBINATION OF POSITIVE VENOUS PULSE WITH IRREGULAR PULSE.

Hering expresses surprise that greater attention is not paid to the jugular pulse, whose curve is the only objective and certain clinical sign of tricuspid insufficiency. He has sometimes encountered it accompanied by regular heart action, at least occasionally regular. But he has never observed a permanently irregular pulse without the positive venous pulse (Kammervenenpuls—"ventricle-vein pulse"). In anemics, on the other hand, he never encountered the "ventricle-vein" pulse, but rather an "auricle-vein" pulse.—H. E. Hering, *Deutsche Medizinische Wochenschrift*, Berlin and Leipsic.

## OBSTETRICS AND DISEASES OF CHILDREN

## LANE MULLALLY, M. D.

## THE TREATMENT OF ABORTION.

H. J. Boldt (*Jour. Am. Med. Ass.*) says before outlining treatment that in regard to the question whether or not abortion is indicated, physicians should be on their guard. That abortion should not be sanctioned in heart disease, when there is dilatation with sufficient hypertrophy to compensate for the dilatation. Neither is it indicated in psychical disturbances or pulmonary diseases, except under special circumstances.

Abortion is indicated in pernicious hyperemesis, and in some cases of chorea.

Boldt claims abortion is indicated in nephritis if the renal disease was present before conception or manifests itself during the first three or four months of gestation.

In deformed pelves, he recommends allowing the patient to decide for herself whether she wishes to go to term and be delivered by Caesarean section or whether she prefers the induction of abortion.

The most favorable time for the induction of abortion is before the third or fourth month of gestation.

Boldt claims the most reliable method is with bougies, if this fails, he packs the uterus with a strip of nosophen, iodoform or sterile gauze.

Boldt divides the treatment of abortion into four parts.

1. Imminent abortion, in which there are signs of abortion, but which subside on appropriate treatment.

2. Progressing abortion in which the actual occurrence can not be prevented.

3. Incomplete abortion in which some part of the products of conception is retained.

4. Complete abortion in which the ovum and its membranes have been completely expelled.

Prophylaxis is recommended in threatened abortion, but when it is evident that abortion cannot be prevented, emptying the uterus as soon as possible with the greatest immediate and subsequent safety to the patient is the object to be desired.

That treatment differs as regards safety according to the physician's surgical training and the patient's surroundings.

Boldt's experience has shown that patients do best when nature is allowed to take its course, unless a positive indication shows itself for intervention.

That intervention should be restricted to those cases alone in which there is absolute indication for it, because nature will take better care of an ovum and its adnexa or of retained remnants than we can with fingers or instruments.

Boldt asserts that he has not found that those who are treated without surgical intervention are in worse health than those subjected to surgical methods. He believes, however, that when there is an elevation of temperature or evidence of decomposition of retained conception products, or in the event of profuse hemorrhage, it is then necessary to resort to artificial means to empty the uterus.

The finger being preferable to the curette, but that special training and local conditions, such as sufficient dilatation of cervix are necessary for successful work with the fingers. The dangers from the curette are perforation of the uterus, which does not offer the same resistance as the non-puerperal uterus, also scraping may so deeply destroy the endometrium that subsequent atresia of the uterine cavity may result.

If the use of a curette is indicated, Boldt recommends a large, broad, sharp curette, as the one of least danger.

In imminent abortion special treatment consists of rest and narcotics, such as codein or morphine, and the avoidance of tampons ice bags and ergot.

In progressing abortion, he recommends packing with gauze the vagina, allowing this to remain for 24 hours and usually when removed the entire ovum will be found expelled behind the gauze.

If not expelled, tampon the uterine cavity with gauze.

If there is profuse hemorrhage, introduce finger and remove contents or use a placental forceps.

If ovum and adnexa have been expelled and bleeding continues though cervix is contracted, ergot is indicated.

Boldt has seen marked benefit derived from the use of stypticin in 3 grain doses given in capsules every 3 hours where uterus was not markedly enlarged and cervix freely contracted and profuse bleeding continued.

Should bleeding continue curette uterus and use one per cent. carbolyzed douche.

When embryo is expelled and placenta retained tampon vagina and give ergot.

In cases of atypical bleeding several days or months after abortion, Boldt recommends dilata-

tion of cervix to admit the finger. This is done usually with steel dilators, but Boldt has practiced dissection of the posterior cervical wall as the most satisfactory method of rendering the uterine cavity rapidly accessible to manual examination. This is afterwards closed with interrupted chromicised catgut sutures.

Where there is evidence of infection, dilating the cervix and cleaning out the uterus is indicated followed by irrigation of one per cent. solution of carbolic acid.

#### DIPHTHERIA ANTITOXIN.

B. F. Royer (*Medicine*), says that it is the custom in the municipal hospitals, in Philadelphia, to give antitoxin to each patient upon being admitted, varying the dose according to the area involved.

If only one tonsil involved, 2500 units; 5,000 units, if both tonsils are involved.

If both tonsils are involved with uvula or pillars, 5,000 to 7,500 units are given.

If nares, pharynx or larynx involved, 7,500 to 10,000 units are administered.

If the membrane does not begin to disappear at once, the dose is repeated in from 12 to 24 hours and continued to be given in 24 hour intervals or in decreasing doses if improvement follows.

30,000 to 60,000 units have been used without success, but as a rule good results are much more common than by the use of smaller doses.

If the exposure has been slight, 500 units are usually sufficient as an immunizing dose, but if the exposure is great, 1,000 units are used.

Royer states that by following this dosage there has not been a case of diphtheria in the hospital among 300 non-infected mothers or children admitted with their relatives.

#### BACTERIOLOGY AND PATHOLOGY.

G. MCF. MOOD. M. D.

##### "CHRONIC BACILLUS CARRIERS AFTER TYPHOID FEVER."

Lentz (*Klin. Jahrbuch*, 1905, vol xiv, p. 475) (*Amer. Jour. of the Med. Sciences*, May, 1906), finds that after convalescence from typhoid fever the patient may harbor the typhoid bacillus for a long time. He considers as "Bacillus Carriers" patients from whom the organisms can be isolated ten weeks after the onset of the disease, or of a relapse. He thinks that about four per cent. of cases become chronic bacillus carriers. In one case, the organism was isolated from the stools forty-two year after an attack of typhoid fever. In this case the organism was obtained over a period of a year and three quarters, and twelve cases of typhoid fever could be traced to it as a source of infection. "The blood serum of these chronic bacillus carriers may or may not give an agglutination reaction. In some of these cases the typhoid bacillus may be found in the stools in almost pure culture, where it practically replaces the colon bacillus, and the organism so found agrees culturally toward animals and immune sera as do bacilli from well defined cases of typhoid fever."



Kutscher (*Berliner klin. Woch.*, 1905, vol. xlii, p. 620), "emphasizes the importance of these cases of chronic bacillus carriers as sources of direct infection. He concludes—that the typhoid bacillus sometimes grows as a saprophyte in the intestine—and believes that the light and unrecognizable infections of typhoid fever are especially dangerous as sources of direct infection."

"The work of Doerr (*Centr. f. Bakt. Orig.*, 1905, vol. xxxix, p. 624) on the development of typhoid bacilli in the gall-bladder throws some light on the subject of these chronic bacillus carriers. His investigation was stimulated by the study of a case in which from the center of gall-stones and pus from the gall bladder pure cultures of the typhoid bacilli were obtained. As the patient has passed gallstones at intervals over a length of time, the author concludes that typhoid bacilli must have been disseminated and the patient have been an unsuspected source of infection for a long time. This condition is believed to be a not uncommon one and must result when the typhoid bacilli becomes part of the harmless flora of the intestinal canal. In evidence that the bacillus may play this part the author cites especially the cases of Droba and Hunner where, seventeen and twenty years respectively after typhoid fever, the organism was isolated from the gall bladder.

"From experiments conducted upon dogs he concludes that the organism enters the gall bladder exclusively through the blood stream. The author believes that in man, where it has been shown that even in very mild attacks of typhoid fever the organism enters the blood, the gall bladder may become infected without recognizable attacks of typhoid fever. We may have, therefore, carriers of the infective agent, which are difficult to recognize, especially as it has been shown that the gall bladder may harbor the typhoid bacillus while the blood serum fails to show any agglutinating properties toward the organism. No drug was found which seemed to have any effect upon clearing the gall bladder of its bacterial contents. The author therefore emphasizes the importance of bacteriological examination of the stools of persons who have suffered from typhoid fever, and of the thorough disinfection of feces."

#### ETIOLOGY OF SYPHILIS."

"Flexner (*Medical News*, Dec. 9, 1905—*American Jour. of the Med. Sciences*, May, 1906), in the Carpenter lectures recently delivered in New York, reviews the literature up to date concerning the spirochaeta pallida and its etiological relationship to syphilis, and also gives an account of his own personal investigations on the subject. It is pointed out that all organisms discovered previous to the spirochaeta pallida and thought to be the specific organisms of syphilis have been conclusively shown not to have any etiological bearing on the disease. The spirochaeta pallida was discovered and named by Schaudinn and Hoffman. They found it in the primary sore, the adjacent enlarged glands, and in the flat condylomata of syphilitic patients.—The spirochaeta is very refractory to stains, and being usually scanty in the lesions is very difficult to find. It stains best with azure blue. The

spirochaeta pallida has been found in the following superficial lesions of the secondary stage: condylomata; macular, papular, and pustular skin lesions. Of the deep structures in this stage in which the organism has been found are the lymphatic glands and spleen. In rare instances it has been found in the circulating blood. Up to the present time, the organism has not with certainty been found in the tertiary stage of the disease. A number of observers have also found spirochaeta pallida in the pemphigus bullae and papules of the skin in congenital syphilis. In 1903 Metschnikoff and Roux announced to the world for the first time, and gave ample proof of their statements that the higher or anthropoid apes were subject to syphilitic inoculation the disease manifesting itself in the form of primary lesions, which after an interval of time, are followed by a syphilitic papular eruption preceded by adenitis. Metchnikoff, Flexner and Kraus have found the spirochaeta pallida in the experimental primary syphilides of monkeys. Kraus, in fact traced it through two monkeys, the second animal having been successfully inoculated with the virus from the first. Although giving the impression that the spirochaeta pallida plays a very important part in the etiology of syphilis, Flexner says: "I am still far from having myself a conviction of its position as immediate cause of that disease, for the establishment of which causal relation more stringent proof than yet produced will be required."

#### SPIROCHAETAE OF SYPHILIS.

Richards and Hunt (*Lancet*, March 10, 1906—*N. Y. Med. Jour.*, March 3, 1906), "divide the spirochaetae found in syphilitic lesions into the following varieties: (1) straight or slightly bent rods in large numbers; (2) undulating organisms showing an attempt to coil; (3) long, delicate, wavy, spiral organisms of great length similar to the spirochaeta Mbermeieri; (4) organisms similar to the last but finer; and (5) the spirochaeta pallida. The first three forms are the same organism at different stages of its existence, the spirochaeta refringens. The fourth variety seems to be an intermediate stage between refringens and pallida. All these forms are found in the primary lesion. The best examples of spirochaeta pallida are obtained from the shotty inguinal glands of the early secondary stage by a puncture with a hypodermic needle under strict antiseptic precautions. The authors hold that spirochaeta pallida is the real specific organism of syphilis; that the organism termed spirochaeta refringens are polymorphic forms of the same organism. It is possible that the spirochaeta pallida circulates freely in the blood and as it develops it becomes spirochaeta refringens."

#### OPHTHALMOLOGY AND OTOTOLOGY.

EDWARD F. PARKER, M. D.

#### CATARACT EXTRACTION.

The success which at the present day attends the operation of cataract extration and the causes that contribute to it.—Theobald, Samuel,

Baltimore (*American Journal of the Medical Science*, January, 1906). The writer states that there can be little question that appreciably better results are obtained at the present time from cataract extraction than 30 years ago and much better than fifty years ago; during the first half of the last century the most skillful surgeons were content if their failures did not exceed twelve per cent.; during the two decades following the introduction of Von Graefe's operation there was a definite improvement in the result secured, though eight to ten per cent. of failures were not uncommon; at the present day an excess of four to 5 per cent. in failures would be considered a poor showing. In a compilation of the results of over 2,000 extractions by well-known ophthalmic surgeons of this country and Europe made by Ring in 1895, the percentage of failures was estimated at 3.87; a similar result is given in about 200 cases operated on by the writer. The causes for the better showing as compared with fifty years ago are given as (1), the improvement in method introduced by von Graefe, (2) the use of cocain, (3) the application of the principles of antiseptic surgery, (4) skilled nursing, (5) improved hospital facilities, (6) provision against postoperative accidents afforded by contrivances such as protective shields, and (7) the more definite specialization of eye surgery. "In view of these many factors tending to promote success in cataract extractions, the pertinent question suggests itself, why do we not obtain better results? Why should there be a failure in every twenty or twenty-five operations for cataract? Why should there be, in addition to these failures, six or seven per cent. of only partial success, in cases in which vision less than one-tenth is secured; The answer is that, in spite of the most careful antiseptic precautions, about two per cent. of the eyes operated on are lost by pyogenic infection; that a not inconsiderable proportion of cataractous eyes are unsound in other respects, and, therefore, not capable of withstanding the shock of operation as they otherwise would; that, as cataract is peculiarly a disease of advanced life, the subjects of it are often not in the best condition for surgical procedures, one per cent. of them being glycosuric, six per cent. albuminuric, and a much larger proportion having atheromatous arteries, and finally, that the temperament of the patient plays a not inconsiderable part in the out-come of every operation for cataract.—(*Ophthalmology* April 1906, C. H. M.)

#### CORNEAL ULCERS.

The treatment of Corneal Ulcers by the General Practitioner. Jones, C. P. Newport News, (*Atlanta Journal-Record of Med.*, December, 1905) calls attention to the origin of this affection from an injury or abrasion which has become infected. This possibility should be borne in mind in every injury of the cornea. The eye should be promptly irrigated with saturated solu-

tion of boric acid, or bichlorid 1 to 4,000, and kept as aseptic as possible by the use of bichlorid ointment. If the injury is as much as twelve hours old and the proper antiseptic precautions have not been taken, the wound should be touched with tincture of iodine, applied by a few shreds of absorbent cotton wound around a small probe or smooth wooden tooth pick. When the ulcer has declared itself, it is thoroughly curetted, and then touched with iodine. If there is no marked improvement after twenty-four hours, it is cauterized either with carbolic acid or with the actual cautery, using a fine platinum probe. Atropin and hot applications are valuable aids at this stage. In a bad case, rest in bed is imperative. —(*Ophthalmology*, April, 1906, P. H. F.)

#### MASTOID OPERATIONS.

The Indication for Operating in Acute Mastoiditis. By. Philip D. Kerrison, M. D. The indications for operating in acute mastoiditis may be summed up somewhat as follows:

(1) Sudden cessation of the aural discharge, other symptoms persisting; deep seated pain in the mastoid region; marked sensitiveness to pressure upon the mastoid over an area extending well beyond the limits of the antrum. These symptoms in the presence of a sudden or considerable rise in temperature would justify an immediate operation.

(2) In the absence of fever, the above symptoms, unless yielding promptly, i. e., in twenty-four to forty-eight hours, to abortive measure, would constitute a sufficient reason for operating upon the mastoid.

(3) Marked tenderness over the antrum, persisting four or five days after free incision of Shrapnel's membrane would point to necrotic changes within the antrum calling for operative intervention.

(4) Marked variations in the quantity of pus discharges; its maximum flow being, apparently, too great to be explained by the tympanic lesion its periods of diminution being coincident with the development of mastoid pain or tenderness (or both). Such a combination of symptoms constitutes one of the most positive indications for opening the mastoid.

(5) Mastoid tenderness having been and having disappeared, a discharge from the tympanic vault, which resists all rational non-operative measures, may, by reason of its persistence, justify the hypothesis of a necrotic area in the aditus of antrum. In such cases an operation is often the only means of saving the integrity of the organ, and preventing serious impairment of function.

(6) Finally, evidences of mastoid involvement having been present, the development, at any time during convalescence, of symptoms of septic absorption, e. g., septic temperature, constitutional exhaustion etc. would in the absence of other concurrent disease constitute a positive indication for immediate operation.—*Manhattan Eye and Ear Hosp. Reports* March 1906.



### INSURANCE EXAMINATION FEES.

#### A Protest from Dr. McCormack, and a Plea That Physicians Stand Together in Opposition to a Gross and Unnecessary Injustice.

BOWLING GREEN, Ky., April 30, 1906.

*To the Editors*—The simultaneous and uniform reduction of fees for medical examinations recently made by the Mutual Life of New York, the Equitable and several other old line life and accident insurance companies and the other information bearing on the same point, leaves little room for doubt that this was done as the result of a carefully prearranged and concerted understanding. Sprung on us midway between the meetings of our national and state associations, without even the courtesy of a notice, or an opportunity for conference or protest, as employers would not now attempt to do in dealing with miners or bricklayers, the profession was taken completely by surprise. Expecting some official action by their organizations, many quietly put the formal acceptance of the reduction requested by the companies in the wastebasket, while many others, without advisors, and not knowing what their competitors would do reluctantly and resentfully signed and returned the agreement. It was all an adroit and well devised plan of the companies to deal with the isolated and individual physician instead of with the organized profession.

And there were abundant reasons for believing that it would succeed. Eleven years before, the New York Life, the original and arch sinner against the best interests alike of their policyholders and the profession in this regard, had cut its fee in the same unceremonious and discourteous way, and probably a majority of leading physicians in all sections of the country failed to resent the recognized indignity. At that time we had no real organization anywhere, the profession was living in more or less suspicion and discord in most communities, and many felt that it would be useless to offer single-handed resistance to this then respected and powerful corporation. But it is far different now. We already have societies in over 2,400 of the 2,830 counties in the United States, with a total of 60,000 members, embracing nearly all of the more progressive and intelligent elements of the profession, and our organization is fresh in its infancy. The counties not yet organized are in the sparsely settled regions and most of those outside of the membership where societies exist want to come in and co-operate with us for the promotion of their own and the common welfare.

In most states many individual county societies have acted promptly in this matter, even without the leadership and concert of action so much needed, while in several states steps have been taken to secure uniform resistance to the injustice. The society of Pike County, Illinois, pledged its members to make no examinations for old line companies for less than \$5, or for industrial or fraternal orders for less than \$2 or \$3, and has requested every other county society in the state to join in the movement. I have been present at meetings almost daily for four weeks where this request met with a most cordial response. A similar policy has been inaugurated Kentucky and other states and can easily be

made general, as the feeling is widespread, not only that the profession was most unjustly and unkindly treated in this matter, but that it was done in such a disdainful and discourteous manner that we cannot submit to it without loss of prestige and dignity.

The requirements of medical examiners have always been exacting. It is now necessary that they should have had four years of special training and several years of practical experience before they are permitted to undertake this important duty. Their selection has always been made with care and from the highest class of the profession. This is eminently proper. Cheap and incompetent doctors are likely to prove as dangerous to the best interests of policy-holders in mutual insurance affairs as they have always been as family physicians. And now this large class of specially trained, selected and loyal men, without the common courtesy of notice or even so much as a "By your leave," are asked to submit to a uniform reduction of fees amounting to practically 40% as most examinations are for small policies. All this is done, too, under the specious and misleading plea of economy, under the leadership of such eminently worthy men as Mr. Paul Morton, who, without a day of training for his duties was taken from a position of high honor, with a salary of \$8,000, and put at the head of the Equitable on a salary of \$80,000, and Messrs. Peabody and Orr, similarly lacking in special training, who have been made presidents respectively of the Mutual and New York Life on salaries of \$50,000 each, the latter being equal to that paid to the President of the United States. These gentlemen succeeded to offices of which they are no doubt in every way worthy, because of the scandal and popular outcry, never before equaled in the financial history of this country, at least partly due to the inordinate and disproportionate salaries paid their predecessors. On the false assumptions that their own compensation had been largely reduced, these still high salaried officials had scarcely warmed their new seats before they began to institute reforms at the expense of their medical subordinates, a popular and long-favored pastime with lay officials of almost every class. It is true that a reduction was made in other departments, in many of which there had been more or less scandal, of 20%, but the medical department, against which, to the honor of our profession be it said, there has never come even a breath of suspicion, having no friends at court to make a plea for it, was summarily reduced 40%. This would have been bad enough if our officials had been given a hearing in our behalf, but I submit that the manner in which it was all done was far more humiliating and hurtful than the financial loss and that it should provoke a manly and dignified resentment at the hands of every lover of his profession.

It is suggested that examiners who have not agreed to accept the reduction go on making examinations whenever requested to do, charging full fees in every instance and bringing suit when not paid wherever legal service can be had on agents. It is advised that others who have formally accepted the reduction under the impression that there would be no uniform resistance, write at once, recalling the same. Our friends are advised not to resign, but simply to "stand

pat". In addition it is urged that every medical man in this country begin at once actively and persistently, to throw his influence to the North-western, Mutual Benefit, Massachusetts Mutual and other well-known and stable companies which have been more honestly and economically managed, and which have also refrained from this unkindness to our already underpaid profession.

If our friends are willing to give the time and trouble to this work which its importance demands, we can easily control the situation in several states and in a majority of counties in a few months can demonstrate what organized medicine stands for in a small field, where no charity or sentiment is involved, and at the same time protect ourselves from injustice from other sources, and encouraged by what seemed would be our tame submission to this great wrong. It is almost equally important, while engaged in this work, to free our members, once for all from the large and almost gratuitous work done for industrial and fraternal orders. This has been in the hands largely of the poorest and humblest in the profession, those least able to protect themselves, and for concerns which relatively sell insurance at the highest price. Their examination requirements are tedious and exacting, and we should insist that their fees be so regulated as to give our less fortunate brethren reasonable compensation,

It has been in my mind to suggest that examiners in every county in the United States secure the proxies of all policy-holders in their respective jurisdiction in the name of the president, secretary or some designated representative of the Association, but it does not seem advisable to do this at present, if at all. It would be easy for the profession to become an important if not a determining factor in the reorganization of most of the companies. Our best interests and those of the policy-holders are mutual and inseparable. Old examiners have the names of all policy-holders in their respective jurisdictions on their ledgers, they know them personally, and on an assurance that our representative will co-operate with the state insurance commissioners and others who are conservatively striving to free these corporations from the evils so long involving them, there should be no great difficulty in securing nearly every proxy in most counties. This would be greatly assisted by the fact that the legislature of New York has recently canceled all outstanding proxies and has postponed the election of new directors until October. This is only a tentative suggestion which came into my mind, and it will not be pressed without the official sanction of the House of Delegates at Boston. It is important that all matters of grave concern like this should be managed in the broad, conservative and statesman-like way which will commend itself to all right-thinking people in and out of the profession.

State and independent journals are respectfully

requested to give this a place in their columns, with such editorial comment as may be deemed proper. It is the duty of our organization, and especially of its official organs, intelligently and conservatively to guard every interest of the rank and file of his profession. The chief agency in doing this and the source of all power for doing it, is in our system of county societies. Most of them have all of the machinery ready at all times, they can be called together on short notice and it is urged that they take such action everywhere as will best safeguard the rights and dignity of their members.

Speaking two or three times every day, and being on the road most of the time when not speaking, this communication has been prepared under great difficulties and is very imperfect. I am not engaged in practice, will probably never make another insurance examination, and consequently have no personal interest in the matter. My reason for taking up the work was that I found our friends at sea about it, indignant and resentful, but without a plan for securing the concert of action so manifest in the policy of those who had visited this unnecessary and unmerited injustice on us and after all, it seemed to come more naturally to my department than any other. I found also that many of those to whom we are accustomed to look for guidance are busy men in other fields, not even indirectly connected with this interest, and hence it is difficult for them to appreciate its importance to the rank and file of the profession.

Since this was written it has been suggested by one of my best personal friends, who is equally interested in one of the great life insurance companies and our profession, that we ought to be estopped from resistance in this matter because we so long submitted to the same injustice from some of the other old line and all of the industrial and fraternal orders. As I have said, we were unorganized then and could only act as individuals. Whether old or new, acute or chronic, the complaint is the same, and my suggestion is that the same remedy is indicated for all of the companies which have adopted this policy at any time and that it be uniformly applied.—*J. N. McCormack in Jour. A. M. A.*

## ASSOCIATION NEWS. . .

DR. FURMAN APPOINTED DELEGATE TO THE MEETING OF THE ASSOCIATION OF STATE MEDICAL JOURNALS.

WHEREAS, At the last meeting of the Association, the House of Delegates omitted the appointment of a delegate to the Meeting of the Association of State Medical Journals to be held in Boston, on June the 4th, 1906. I hereby appoint Dr. Davis Furman, of Greenville, to represent our Association on that occasion.

T. P. WHALEY, M. D.  
President S. C. Med. Association.



## AFFILIATED COUNTY SOCIETIES WITH MEMBERS.

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(ABBEVILLE COUNTY MEDICAL SOCIETY.)

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J. R. Bell.....	Due West.
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J. B. Britt.....	Troy.
J. M. Carlton.....	Mt. Carmel.
C. C. Gambrell.....	Abbeville.
F. E. Harrison.....	Abbeville.
L. T. Hill.....	Abbeville.
J. W. Keller.....	Abbeville.
T. O. Kirkpatrick.....	Lowndesville.
D. S. Knox.....	Autreville.
Frank Lander.....	Williamston.
W. E. Link.....	Williamston.
S. Mare.....	Anderson.
G. A. Neuffer.....	Abbeville.
W. H. Pepper.....	Anderson, R. F. D.
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(ANDERSON COUNTY MEDICAL ASSOCIATION.)

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R. B. Day.....	Pendleton.
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J. L. Gray.....	Anderson.
J. C. Harris.....	Anderson.
S. R. Hiller.....	Townville.
W. R. Haynie.....	Belton.
B. A. Henry.....	Anderson.
W. S. Hutcherson.....	Anderson, R.F.D.
W. H. Nardin.....	Anderson.
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(AIKEN COUNTY MEDICAL SOCIETY.)

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B. S. Dunn.....	Aiken.
T. P. Edwards.....	Graniteville.
W. S. Eubanks.....	Talatha.
P. H. Eve.....	Augusta, Ga. [R. F. D. No. 3]
J. I. Green.....	Bath.
T. Hall.....	Aiken.
M. M. Lecroy.....	Langley.
W. E. Mealing.....	North Augusta.
C. F. McGahan.....	Aiken.
J. B. McMillan.....	Graniteville.
J. A. Millhouse.....	Perry.
V. Mott.....	Aiken.
H. J. Salley.....	Salley.
W. H. Shaw.....	Langley.
C. A. Teague.....	Graniteville.
W. C. R. Turnbull.....	Aiken.
J. R. A. Whitlock.....	Kitchen's Mill.

W. A. Whitlock.....	Kitchen's Mill.
W. D. Wright.....	Langley.
B. F. Wyman.....	Aiken.
J. F. Wyman.....	Aiken.
H. H. Wyman, Sr.....	Aiken.
H. Hastings Wyman, Jr.....	Aiken.
Harry H. Wyman.....	Aiken.

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(BAMBERG COUNTY MEDICAL SOCIETY.)

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R. Black.....	
H. M. Brabham.....	
V. W. Brabham.....	
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R. S. Kirk.....	Charleston.
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Jos. Maybank.....	Charleston.
Wm. Mazyck.....	Charleston.
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J. C. Mitchell.....	Charleston.
G. McF. Mood.....	Charleston.

Lane Mullally .....	Charleston.
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F. L. Parker, Hon., .....	Charleston.
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C. M. Rees .....	Charleston.
Edw. Rutledge .....	Charleston.
T. M. Scharlock .....	Charleston.
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T. P. Whaley .....	Charleston.
G. F. Wilson .....	Charleston.
J. LaR. Wilson .....	Charleston.
Robt. Wilson .....	Charleston.

## CHEROKEE.

(CHEROKEE COUNTY MEDICAL SOCIETY.)

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M. W. Smith .....	Gaffney.
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## CHESTER.

(CHESTER COUNTY MEDICAL SOCIETY.)

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J. G. Johnston .....	Chester.
T. B. Kell .....	Catawba.
H. E. McConnell .....	Chester.
C. A. McLurkin .....	Halselville.
C. B. McKeown .....	Fort Lawn.
S. G. Miller .....	Chester.
S. W. Pryor .....	Chester.
W. DeK. Wylie .....	Richburg.
A. M. Wylie .....	Chester.
J. P. Young .....	Richburg.

## CLARENDON.

(CLARENDON COUNTY MEDICAL SOCIETY.)

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Heyward Wood .....	Turbeville.
I. M. Wood .....	Sardinia.

## COLLETON.

(COLLETON COUNTY MEDICAL SOCIETY.)

*Secretary, C. H. Es Dorn, Walterboro.*

Riddick Ackerman .....	Walterboro.
W. B. Ackerman .....	Walterboro.

C. H. Es Dorn .....	Walterboro.
T. G. Kershaw .....	Youngs Island.
W. A. Kirby .....	Cottageville.
J. B. Padgett .....	Getsinger.
B. G. Willis .....	Cottageville.
H. A. Willis .....	Hendersonville.
J. T. Taylor .....	Adams Run.

## DORCHESTER.

(DORCHESTER COUNTY MEDICAL ASSOCIATION.)

*Secretary, J. B. Johnston, St. George's.*

J. H. Abbott .....	St. George.
W. M. Carn .....	St. George.
F. J. Carroll .....	Summerville.
J. T. Carter .....	Bowman.
J. D. Conner .....	Branchville.
J. L. B. Gilmore .....	Holly Hill.
M. S. Gressett .....	Branchville.
G. B. Harley .....	Dorchester.
A. A. Horger .....	Harleyville.
P. L. Horn .....	St. George.
A. R. Johnston .....	Reevesville.
G. A. T. Johnston .....	Ridgeville.
J. B. Johnston .....	St. George.
J. P. Johnston .....	Reevesville.
P. M. Judy .....	St. George.
H. B. Lee .....	Summerville.
L. J. Mann .....	Branchville.
D. . Moorer .....	St. George.
W. M. Moorer .....	Lodge.
J. P. Mellard .....	St. George.
W. P. Shuler .....	Grover.
M. G. Salley .....	Orangeburg.
E. D. Tupper .....	Summerville.
W. B. Way .....	Ridgeville.
S. P. Wells .....	Holly Hill.
J. S. Wimberly .....	Branchville.

## FLORENCE.

(FLORENCE COUNTY MEDICAL SOCIETY.)

*Secretary, Wm. Ilderton, Florence.*

A. G. Eaddy .....	Florence.
N. W. Hicks .....	Florence.
Wm. Ilderton .....	Florence.
T. C. Johnson .....	Mars Bluff.
J. D. Lewellen .....	Friendfield.
F. H. McLeod .....	Florence.
W. E. Mills .....	Timmons ville.
O. C. Odell .....	Friendfield.
R. H. Pearce .....	Clausens.
J. H. Pearce .....	Cartersville.
W. L. Whitehead .....	Timmons ville.
M. B. Young .....	Georgetown.

## GEORGETOWN.

(GEORGETOWN COUNTY MEDICAL SOCIETY.)

*Secretary, W. M. Gaillard, Georgetown.*

C. W. Bailey .....	Georgetown.
H. D. Beckman .....	Georgetown.
J. W. Folk .....	South Island.
W. M. Gaillard .....	Georgetown.
Covington Lee .....	Harpers.
M. P. Moorer .....	Georgetown.
W. D. Simpson .....	Georgetown.
O. Sawyer .....	Georgetown.
W. E. Sparkman .....	Georgetown.
W. B. Young .....	Georgetown.

## GREENVILLE.

(GREENVILLE COUNTY MEDICAL SOCIETY.)

*Secretary, J. A. Hayne, Greenville.*

T. W. Bailey .....	Greenville.
W. C. Black .....	Greenville.



G. H. Bottum.....	Greenville.
E. W. Carpenter.....	Greenville.
L. G. Corbett.....	Greenville.
C. B. Earle.....	Greenville.
J. B. Earle.....	Greenville.
T. T. Earle.....	Greenville.
Davis Furman.....	Greenville.
C. T. J. Giles.....	Greenville.
B. F. Goodlett.....	Travelers Rest.
J. A. Hayne.....	Greenville.
E. B. Hendrix.....	Reedy River.
R. E. Houston.....	Greenville.
F. G. James.....	Greer.
J. W. Jervey.....	Greenville.
C. C. Jones.....	Greenville.
W. L. Marchant.....	Geers.
G. L. Martin.....	Greenville.
W. Y. McDaniel.....	Taylor.
J. E. McKinney.....	Greenville.
W. L. Mauldin, Jr.....	Greenville.
W. S. Pack.....	Greenville.
L. L. Richardson.....	Simpsonville.
H. L. Shaw.....	Fountain Inn.
R. D. Smith.....	Greenville.
L. C. Stevens.....	Greenville.
G. T. Swandale.....	Greenville.
J. R. Ware.....	Greenville.
A. Wallace.....	Greenville.
C. Q. West.....	Greenville.
A. White.....	Mauldins.
W. E. Wright.....	Greenville.

## GREENWOOD.

(GREENWOOD COUNTY MEDICAL SOCIETY.)

*Secretary, J. B. Huger, Greenwood.)*

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J. E. Brunson.....	Ninety-Six.
E. O. Devlin.....	Verdery.
R. B. Epting.....	Greenwood.
J. C. Harper.....	Greenwood.
J. E. Hughey.....	Greenwood.
E. O. Jenkins.....	Troy.
W. Townes Jones.....	Cokesbury.
Willie T. Jones.....	Jones.
John Lyon.....	Ninety-Six.
G. P. Neel.....	Greenwood.
J. B. Owens.....	Greenwood.
W. P. Turner.....	Coronaca.
W. Townes.....	Cokesbury.
S. L. Swygert.....	Greenwood.
A. H. Wideman.....	Bradley.

## HAMPTON.

(HAMPTON COUNTY MEDICAL SOCIETY.)

*Secretary, C. A. Rush, Hampton.*

Paul F. Bowers.....	Luray.
J. W. Colson.....	Varnville.
J. L. Folk.....	Brunson.
N. C. Johnson.....	Luray.
F. J. McKinley.....	Hampton.
E. C. B. Mole.....	Early Branch.
M. B. Monsen.....	Luray.
C. R. Peebles.....	Estill.
C. A. Rush.....	Hampton.
Southward Smith.....	Garnett.
C. P. Vincent.....	Varnville.
C. P. Walter.....	Crockettsville.
T. B. Whatley.....	Gillisonville.

## HORRY.

(HORRY COUNTY MEDICAL SOCIETY.)

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J. S. Dusenbury.....	Conway.
J. W. Floyd.....	Green Sea.
E. Norton.....	Conway.
J. A. Norton.....	Conway.
R. G. Sloan.....	Little River.
A. B. Walters.....	Conway.
S. P. Watson.....	Mattie.

## KERSHAW.

(KERSHAW COUNTY MEDICAL ASSOCIATION.)

*Secretary, S. C. Zemp, Camden.*

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A. W. Burnet.....	Camden.
J. W. Corbett.....	Camden.
W. R. Clyburne.....	Camden.
W. J. Dunn.....	Camden.
J. T. Hay.....	Boykins.
J. W. A. Sanders.....	Longtown
S. C. Zemp.....	Camden.

## HONORARY.

D. L. DeSaussure.....	Camden
A. A. Moore.....	Camden.

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(LAURENS COUNTY MEDICAL SOCIETY.)

*Secretary, R. E. Hughes, Laurens.*

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J. J. Boozer.....	Laurens.
J. W. Beason.....	Gray Court.
A. J. Christopher.....	Laurens.
W. H. Dial.....	Laurens.
C. D. East.....	Goldville.
J. L. Fennell.....	Waterloo.
W. D. Furguson.....	Laurens.
J. H. Teague.....	Laurens.
R. E. Hughes.....	Laurens.
J. H. Miller.....	Cross Hill.
E. W. Pinson.....	Cross Hill.
J. T. Poole.....	Laurens.
C. A. Saxon.....	Tylersville.
Isadore Shayer.....	Laurens.
E. F. Taylor.....	Renno.
J. O. Wilbur.....	Waterloo.
J. L. Young.....	Clinton.
J. W. Young.....	Clinton.

## LEE.

(LEE COUNTY MEDICAL SOCIETY.)

*Secretary, L. H. Jennings, Bishopville.*

A. C. Baskins.....	Bishopville.
A. H. Brown.....	Rural.
C. S. Britton.....	Smithville.
J. B. Bullock.....	Lucknow.
J. D. Foxworth.....	Smithville.
B. L. Harris.....	St. Charles.
L. H. Jennings.....	Bishopville.
J. B. Manning.....	Bishopville.
B. McLaughlin.....	Bishopville.
R. Y. McLeod.....	Bishopville.
J. E. McLure.....	Bishopville.
L. H. Peebles.....	Rural.
J. W. Parks.....	Smithville.
J. W. Tarrant.....	Lynchburg.

## LEXINGTON.

(LEXINGTON COUNTY MEDICAL SOCIETY.)

*Secretary, J. J. Wingard, Lexington.*

C. W. Barron.....	New Brookland.
D. M. Crosson.....	Leesville.
E. P. Derrick.....	Lexington.
H. G. Eleazor.....	Peak.
L. B. Etheridge.....	Leesville.
J. P. Drafts.....	Gilbert.
F. R. Geiger.....	New Brookland.
J. W. Geiger.....	Shumpert.
R. E. Mathias.....	Irmo.
Theo. A. Quattlebaum.....	Batesburg.
J. L. Shuler.....	Selwood.
W. H. Timmerman.....	Batesburg.
W. Price Timmerman.....	Batesburg.
J. W. Wessinger.....	Ballantine.
J. J. Wingard.....	Lexington.

## MARION.

(MARION COUNTY MEDICAL SOCIETY.)

*Secretary, H. A. Edwards, Latta.*

B. M. Badger.....	Dillon.
A. M. Brailsford.....	Mullins.
F. L. Carpenter.....	Latta.
E. M. Dibble.....	Marion.
H. A. Edwards.....	Latta.
C. T. Ford.....	Mullins.
C. Henslee.....	Dillon.
A. D. Lewis.....	Nichols.
E. C. Major.....	
A. McIntyre.....	Marion.
J. G. Rogers.....	Poges Mill.
F. A. Smith.....	Mullins.
Z. G. Smith.....	Marion.
E. B. Utley.....	Marion.

## MARLBORO.

(MARLBORO COUNTY MEDICAL SOCIETY.)

*Secretary, J. H. Reese, Tatum.*

L. E. Bull.....	Cheraw.
W. J. Crosland.....	Bennettsville.
C. S. Evans.....	Clio.
J. A. Faison.....	Bennettsville.
D. Hamer.....	McColl.
J. A. Hamer.....	Clio.
J. L. Jordan.....	Bennettsville.
J. F. Kinney.....	Bennettsville.
C. R. May.....	Blenheim.
J. W. McCanless.....	Chesterfield.
J. C. Moore.....	McColl.
C. D. Napier.....	Blenheim.
J. L. Napier.....	Blenheim.
W. M. Reedy.....	Clio.
J. H. Reese.....	Tatum.
A. S. Townsend.....	Bennettsville.
J. A. Woodley.....	Tatum.

## NEWBERRY.

(NEWBERRY COUNTY MEDICAL SOCIETY.)

*Secretary, J. J. Dominick, Prosperity.*

J. I. Badenbaugh.....	Prosperity.
J. J. Dominick.....	Prosperity.
W. A. Dunn.....	Newberry.
P. G. Ellisor.....	Newberry.
O. B. Evans.....	Kinards.
J. K. Gilder.....	Newberry.
W. G. Houseal.....	Newberry.
G. Y. Hunter.....	Prosperity.
J. M. Kibler.....	Newberry.
W. E. Lake.....	Newberry.

O. B. Mayer.....	Newberry.
W. E. Pelham, Jr.,.....	Newberry.
W. D. Senn.....	Newberry.
J. S. Wheeler.....	Prosperity.
C. T. Wyche.....	Prosperity.

## OCONEE.

(OCONEE COUNTY MEDICAL SOCIETY.)

*Secretary, D. L. Smith, Newry.*

J. W. Bell.....	Walhalla.
E. C. Doyle.....	Seneca.
W. R. Doyle.....	Seneca.
E. A. Hines.....	Seneca.
J. H. Moore.....	Walhalla.
A. M. Redfern.....	Clemson.
— Rosser.....	Westminster.
B. F. Sloan.....	Walhalla.
D. L. Smith.....	Newry.
J. H. Stribling.....	Seneca.
C. M. Walker.....	Westminster.
J. M. Wickliffe.....	West Union.

## PICKENS.

(PICKENS COUNTY MEDICAL SOCIETY.)

*Secretary, H. E. Russell, Easley.*

J. E. Allgood.....	Liberty.
J. L. Bolt.....	Pickens.
L. G. Clayton.....	Central.
R. J. Gilliland.....	Easley.
R. Kirksey.....	Pickens.
W. M. Long.....	Liberty.
L. O. Mauldin.....	Pickens.
L. F. Robinson.....	Dacusville.
J. O. Rosamond.....	Easley.
H. E. Russell.....	Easley.
W. A. Sheldon.....	Pickens.
W. A. Tripp.....	Easley.
E. B. Webb.....	Liberty.
C. N. Wyatt.....	Easley.

## RICHLAND.

(COLUMBIA MEDICAL SOCIETY.)

*Secretary, Mary R. Baker, Columbia.*

E. C. L. Adams.....	Columbia.
Sarah C. Allan.....	Columbia.
J. W. Babcock.....	Columbia.
A. E. Boozer.....	Columbia.
Mary R. Baker.....	Columbia.
W. A. Boyd.....	Columbia.
J. H. Burkhalter.....	Columbia.
G. H. Bunch.....	Columbia.
Hubert Clator.....	Hopkins.
S. M. Deal.....	Columbia.
T. M. DuBose.....	Columbia.
S. B. Fishburne.....	Columbia.
R. W. Gibbs.....	Columbia.
H. H. Griffin.....	Columbia.
L. A. Griffith.....	Columbia.
LeGrand Guerry.....	Columbia.
Jane B. Guignard.....	Columbia.
S. E. Harmon.....	Columbia.
Henry Horlbeck.....	Columbia.
A. B. Knowlton.....	Columbia.
R. A. Lancaster.....	Columbia.
W. M. Lester.....	Columbia.
A. A. Madden.....	Columbia.
J. H. McIntosh.....	Columbia.
P. V. Mikell.....	Columbia.
R. L. Moore.....	Columbia.
L. B. Owens.....	Columbia.
Lindsay Peters.....	Columbia.
L. K. Philpot.....	Columbia.
D. S. Pope.....	Columbia.



H. W. Rice .....	Columbia.
A. E. Shaw.....	Columbia.
S. B. Sherard.....	Columbia.
J. H. Taylor.....	Columbia.
J. L. Thompson .....	Columbia.
E. J. Wannamaker.....	Columbia.
J. J. Watson.....	Columbia.
William Weston .....	Columbia.
E. M. Whaley.....	Columbia.
C. F. Williams.....	Columbia.

## SALUDA.

(SALUDA COUNTY MEDICAL SOCIETY.)

*Secretary, J. D. Waters, Coleman.*

F. G. Asbill.....	Ridge Spring.
D. B. Frontis.....	Ridge Spring.
J. J. Kirksey.....	Saluda.
S. M. Pitts.....	Big Creek.
L. J. Smith.....	Ridge Spring.
W. B. Smith.....	Wards.
G. L. Trotter.....	Wards.
J. D. Waters.....	Coleman.
O. P. Wise.....	Saluda

## SPARTANBURG.

(SPARTANBURG COUNTY MEDICAL SOCIETY.)

*Secretary, O. W. Leonard, Spartanburg.*

A. M. Allen.....	Sp'bg, R.F.D. No. 4
J. H. Allen.....	Spartanburg.
J. W. Allen.....	Enoree.
H. R. Black.....	Spartanburg.
L. J. Blake.....	Spartanburg.
J. R. Brown.....	Spartanburg.
G. A. Bunch.....	Spartanburg.
W. J. Chapman.....	Inman.
	[R. F. D. No. 2.
W. P. Coan.....	Spartanburg.
	[R. F. D. No. 5.
A. D. Cudd.....	Spartanburg.
Geo. R. Dean.....	Spartanburg.
R. M. Dorsey.....	Spartanburg.
J. P. Dupree.....	Clifton.
J. Ed. Edwards.....	Spartanburg.
A. R. Fike.....	Spartanburg.
C. W. Gentry.....	Enoree.
T. D. Hairston.....	Clifton.
J. R. Gibson.....	Inman.
R. G. Hamilton.....	Converse.
Geo. W. Heinitsch.....	Spartanburg.
J. L. Jefferies.....	Spartanburg.
W. H. Kelly.....	Walnut Grove
W. L. Kirkpatrick.....	Pacolet.
S. T. D. Lancaster.....	Pauline.
J. M. Lanham.....	Woodruff, R.F.D.
O. W. Leonard.....	Spartanburg.
J. J. Lindsav.....	Spartanburg.
D. R. Norman.....	Fair Forest
H. E. McDowell.....	Spartanburg.
Geo. E. Means.....	Welford.
J. D. Orr.....	Spartanburg.
S. D. Parsons.....	Woodruff. R.F.D.
W. B. Patton.....	Cross Anchor.
E. O. Posey.....	Woodruff. R.F.D.
F. L. Potts.....	Spartanburg.
Chas. E. Rogers.....	Duncans.
W. G. Sexton.....	Spartanburg.
A. C. Smith.....	Glenn Springs.
W. A. Smith.....	Glendale.
H. B. Tate.....	Pacolet.
George Thompson.....	Inman, R. F. D.
John O. Vernon.....	Welford.
Lee J. Wall.....	Spartanburg,

S. A. Wideman.....	Woodruff, R.F.D.
J. F. Williams.....	Roebuck.
H. H. Workman.....	Woodruff.
G. DeFoix Wilson.....	Spartanburg.

## SUMTER.

(SUMTER COUNTY MEDICAL SOCIETY.)

*Secretary, Walter Cheyne, Sumter.*

S. C. Baker.....	Sumter.
E. M. Carson.....	Sumter.
J. J. Bossard.....	Sumter.
Walter Cheyne .....	Sumter.
Archie China .....	Sumter.
F. M. Dwight.....	Wedgfield.
R. B. Furman.....	Sumter, R.F.D. No. 1.
J. A. Mood.....	Sumter.
C. P. Osteen.....	Sumter.
M. L. Parler.....	Wedgfield.
P. M. Salley.....	Pinewood.
J. C. Spann.....	Sumter.
H. M. Stuckey.....	Sumter.

## UNION.

(UNION COUNTY MEDICAL SOCIETY.)

*Secretary, S. G. Sarratt, Union.*

C. W. Austell.....	Union.
R. R. Berry.....	Buffalo.
J. C. Brawley.....	Lockhart.
E. M. Carson.....	Sumter.
M. W. Chambers.....	Jonesville.
M. W. Culp .....	Union.
W. J. Douglass.....	Jonesville.
J. G. Goings.....	Union.
H. T. Hames.....	Jonesville.
J. H. Hamilton.....	Union.
O. L. P. Jackson.....	Union.
J. T. Jeter.....	Santuc.
J. M. Lawson.....	Union.
Theo. Maddox.....	Union.
D. H. Montgomery.....	Union.
S. G. Sarratt.....	Union.
W. O. Southard.....	Jonesville.
C. Torrence .....	Union.
L. J. Wood.....	Kelton.

## WILLIAMSBURG.

(WILLIAMSBURG COUNTY MEDICAL SOCIETY.)

*Secretary, L. B. Salters, Lake City.*

T. P. Hinnant.....	Lake City.
S. W. B. Courtenay.....	Lake City.
L. B. Salters.....	Lake City.
J. D. Whitehead.....	Lake City.

## YORK.

(YORK COUNTY MEDICAL SOCIETY.)

*Secretary, J. R. Miller, Rock Hill.*

Jno. I. Barron.....	Yorkville.
I. A. Bigger.....	Clover.
R. A. Bratton.....	Yorkville.
J. J. Campbell.....	Clover.
J. W. Campbell.....	Clover.
L. L. Campbell.....	Clover.
T. R. Carothers.....	Rock Hill.
T. A. Crawford.....	Rock Hill.
T. N. Dulin.....	Clover.
W. W. Fennell.....	Rock Hill.
W. A. Hood.....	Hickory Grove.
T. B. Hough.....	Tirza.
W. M. Love.....	McConnellsville.
J. E. Massey.....	Rock Hill.
J. E. Massey, Jr.....	Rock Hill.
J. D. McDowell.....	Yorkville.
B. N. Miller.....	Smyrna.
J. R. Miller.....	Rock Hill.

E. W. Pressley.....	Clover.
J. H. Saye.....	Sharon.
W. G. Stevens.....	Rock Hill.
M. J. Walker.....	Yorkville.
T. S. R. Ward.....	Hickory Grove.
W. G. White.....	Yorkville.

HONORARY FELLOWS.

1870.....	F. L. Parker.....	Charleston.
1871.....	T. G. Simons.....	Charleston.
1872.....	J. C. Spann.....	Catchall.
1873.....	A. A. Moore.....	Camden.
1873.....	M. G. Salley.....	Pinewood.
1873.....	R. L. Brodie.....	Charleston.
1874.....	W. H. Nardin.....	Anderson.
1874.....	J. F. Pearce.....	Claussens.
1874.....	O. B. Mayer.....	Newberry.
1875.....	T. G. Croft.....	Aiken.
1875.....	Manning Simons .....	Charleston.

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Prof. Samuel Logan.....	New Orleans, La.
Dr. D. M. Prince.....	Laurenburg, N. C.
Dr. Joseph Price.....	Philadelphia, Pa.
Dr. H. O. Marcy.....	Boston, Mass.
Dr. Howard Kelly.....	Baltimore, Md.
Dr. C. U. Shepard.....	Summerville, S. C.
Dr. H. A. Hare.....	Philadelphia, Pa.
Dr. Wharton Sinkler.....	Philadelphia, Pa.
Dr. William T. English.....	Pittsburg, Pa.
Dr. L. S. McMurtry.....	Louisville, Ky.
Dr. George Ben Johnston.....	Richmond, Va.
Dr. James P. Tuttle.....	New York, N. Y.
Prof. J. H. Musser.....	Philadelphia, Pa.

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Bamberg.	Darlington.
Beaufort.	Edgefield.
Berkeley.	Lancaster.
Chesterfield.	Orangeburg.





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